THE INTRODUCTION OF HEALTH INSURANCE IN THE RUSSIAN FEDERATION: AN ANALYSIS OF THE REFORMS IN ST. PETERSBURG AND VOLGOGRAD

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Signed Declaration

I declare that this PhD thesis is entirely my own work. It has not been submitted for any other degree or professional qualification.

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1 July 2002.

ABSTRACT

This thesis examines the introduction of compulsory medical insurance in the Russian Federation in the 1990s as part of the re-structuring of welfare in the years after communism. The reforms brought in strong decentralisation of governance in comparison to Soviet rule. Minimal national legislation and guidance, subsequent adjustments in the face of implementation problems and a pattern of "negotiated federalism" have led to wide variation in regional systems within Russia. This thesis looks in particular at implementation in two federal units (from 89): Volgograd Oblast' and St. Petersburg City.

In the first part, it considers the decision to introduce insurance in the context of the international health care debate, and examines the relationship between health care reform and broader issues of the "transition" away from communism to the market. Particular attention is drawn to how these two discourses in practice have run contrary to each other. It also documents experimental internal market health reform in the Gorbachev era in Leningrad (St. Petersburg), as well as the genesis, formulation and implementation of health insurance at the national level.

The main body of the thesis considers the development of compulsory health insurance in the two research sites, drawing primarily on interview data from 34 interviews with representatives of the main actors within the new system –the municipal administration, parastatal funds and insurance companies – as well as representatives of the health care workforce. Of particular significance is found to be: the impact of financial shortages on the viability of insurance; the extent to which elements of Russian local government reform can undermine regional health care governance; the innovation of decentralisation and the introduction of elements of contract and negotiation in place of vertical command and control structures; and conflict between parastatal health funds and insurance companies. In general the St. Petersburg system was more successful than that in Volgograd. The former was fortunate in its local government structures and in its legacy of institutional reform in health care, but also key policy choices have simplified the systems operation. In Volgograd Oblast' the system suffers from over complexity, institutional conflict and a lack of clear and effective governance structures.

Using testimony and analysis from Russian newspaper and journal archives these issues are explored across Russia. Regional statistical material drawn from a wide range of sources is employed to consider what might be the main determinants/pre-conditions (economic, political, demographic) in system design. Drawing five main conclusions in relation to the material above, the thesis additionally argues that "marketisation", although partly the inspiration for the new system, is unhelpful as an analytical tool; that the main strength of the reforms has been to stabilise health care financing, but that without sufficient funds it may serve to reinforce Soviet-era distributional inefficiencies rather than solve them.

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1. Introduction

"While many Western Health economists now fear Russia's shift to an insurance-based system is doomed, Komarov sees it as the only hope"

The opinion of Yuri Komarov, head of the prominent think-tank (MedSotsEconInform, cited in Moore (1999)

In June 1991, the Russian Federation, still part of the Soviet Union but in the process of breaking away, passed a law for the introduction of compulsory medical insurance. The new financing mechanism was intended partly to replace the system of state financing that had been in place from just after the revolution, partly to supplement what was an under-funded sector, and partly to invigorate it with the energy of the market. It foresaw an initial growth in voluntary insurance, which (it was hoped) would develop institutions that within two years would allow for full compulsory coverage of the population by independent insurance companies through the workplace, or municipal authority for those not employed. This new insurance system was to be organised at the regional level: each of the 89 "subjects" of the Russian Federation was to organise its own system in line with the federal blueprint.

However, voluntary insurance did not develop on a sufficient scale (indeed, outside the rich city-subjects Moscow and to some extent St. Petersburg, it hardly developed at all) to allow for the transition to compulsory insurance. Amendments to the law in 1993 created regional funds that would collect and distribute contributions among the insurance companies on its territory, and be responsible for the stability of the system. And if necessary, it could step in to insure those citizens whose employers or local authority could not find a suitable insurer. As a result of this last provision the structure of health care financing began to vary dramatically amongst regions. In only a few regions did the insurance medical organisations establish themselves as the sole mediator of compulsory funds; in many others, they simply didn't operate. In those latter regions, the parastatal regional funds became the sole purchaser within the guaranteed state system. A large number of regions found themselves operating in a mixed system, with the funds and the insurance companies insuring alongside each other, in a complex and often uneven institutional arrangement. Arguments have subsequently arisen about duplication of functions, incompetent monitoring of quality and corruption, against a backdrop of chronic under-funding and conflict between federal, regional and local health departments.

In separating the purchasers and providers of health services, and trying to encourage a choice of insurer, the new insurance system was in part a movement towards introducing markets and competition into health care. As the struggle for many states over the decades had been to introduce *greater* state involvement in health care against the market and private practice, and as much research had suggested that centralised state-financed health systems were the cheapest to run (for a variety of reasons), it seemed a good question to ask – why were the Russians moving away from this system? Was it part of the rejection of the state that the fall of communism was supposed to engender? What was the relationship between changes in health care and broader changes in the make up of the social state? Was it a return to the European fold of social insurance, or a step towards the free-market "vogue" in health care that blossomed with limited success in the late 1980s and 1990s (cf. Glaser 1993; Richards 1996)? Indeed, was it part of an overall neo-liberal programme applying markets in all areas of social life, regardless of sectoral specificities? Beyond this speculation, how has a country, and especially a bureaucracy accustomed to authoritarian centralised rule coped with plural structures in one of the primary social services?

This is a wide variety of questions. This thesis seeks to answer them by considering the broad social context of the "transition" as it relates to health and health care reform; by considering the international context of health care reform and Russia's position in it as, paradoxically, a developed health system in a poor country, and in the main body of the work, by considering the development of health insurance in two particular sites – St. Petersburg and Volgograd Oblast', where interviews were undertaken in two visits to each respectively (separated by Christmas) September 1998 – March 1999. The decentralisation of the post-communist period, embodied both in the vague and contradictory federal law on health insurance and in radical reform in local government, has created conditions for dramatic variety in health care organisation across the 89 regions of Russia. Prior to this there were already internal market experiments in health care in the late 1980s in three of Russia's regions, including Leningrad as was. Part of this story, then, is looking back into the last years of Soviet government, and at the *Perestroika* era response to the problems of an under-funded and inflexible health system. Part is seeking to broaden out to the rest of Russia, see how the experience of the two sites is common to other regions, and how the research may inform our understanding of health care in Russian regions in general.

English-language literature on the Soviet and Russian health systems has been fairly sparse, considering the size and significance of the country, and the special part the health system played in boasting the achievements of socialism. In Soviet Studies, there were relatively

few books dedicated to the health system (notably Field 1967, Ryan 1978). On the whole it was considered either in passing, or as part of the welfare state as a whole (*e.g.* Manning and George 1980). This general neglect was explained by Ryan in the context of what made the Soviet Union important, and how it ran its affairs: "The strategies pursued in this area of activity are not likely to cause repercussions at an international level and consequently attract less interest...Another reason, and an especially weighty one, is the difficulty of obtaining precise and comprehensive information about the delivery of Soviet medical care" (1978: 1). As a result, much knowledge had to be derived from domestic newspaper articles whose openness could not be assured, émigré reports and occasional visits to see those better institutions that foreigners could be permitted to see. Mark Field's impressive knowledge of problems in the system during Soviet times is testament to his diligence.

In the 1990s, with the country opening up there has been a greater opportunity to study all aspects of social life across the country. One of the main foci has been the demographic situation. This was understandable – population data, no longer in the realms of state secrecy, was becoming available in English, and the tools and expertise for analysing the data were already to hand. Moreover, the extent of the problems in Russia – an increase in mortality comparable only with countries experiencing war – was most certainly worthy of attention. By comparison, consideration of the health care system's organisation and financing was, initially, not researched so deeply. The uncertainty around the final form of the medical insurance system (several amendments were made in April 1993 to make the law workable) led to some ambiguous writing, which in particular did not clearly separate some of the experimental reforms that were introduced under Gorbachev, and the new health insurance system. (*e.g.* Sheiman 1994, Barr and Field 1995, Isakova, Zelckovich and Frid 1995). Part of this was certainly not entirely the fault of the authors; in particular Igor Sheiman, who had taken part in the design of the law, simply did not make clear that he was writing about special cases in Russia (although his early focus on developments in these regions was based upon a prediction for the development of health services in the regions that was not borne out). Other articles considered the health reforms from the perspective of Western discourse on health reform – seeking to use the new Russian model to test whether Western models are valid forms of analysis, rather than examining what is happening on the ground (Curtis, Petukhova and Taket, 1995, Sinuraya 2000). As a result there has been one tendency to consider the health system as it is on paper, rather than the more murky issues of its operation in reality. The other marked tendency is fuelled by the appalling health statistics coming out of Russia, and is found mainly in the Western media: that in Russia the health sector is either collapsing or stagnant. This sort of approach has been unhelpful insofar as it

focuses on worst-case anecdotal evidence, is often connected with journalistic forays outside of Moscow where the greater poverty of most of the rest of Russia generates doom-laden prose. In particular, the health insurance system as a symbol of change is often blamed, or called ineffective, when, as indicated in the quotation at the top of this article, the new financing mechanism appears to be the only stable source of funding in many regions, and indeed is supported by a majority of those involved at the regional administrative level (MG 31.3.95/4), as it was, ultimately, by most respondents in this study.

In general, there are few articles in English-language journals that seek to talk about the practical operation of the new system in Russia with any depth of research. However, particular mention should be made of Twigg (1998; 1999, 2001); Burger, Field and Twigg (1997) and Duffy (1997). In these the predominant focus is on what is happening at the centre of Russian politics, and a persistent interest in looking at the health systems through the prism of marketisation. Although the process of transition and marketisation is a central part of understanding the health reform in Russia, I feel it is not always helpful to use it as a mode of analysis, and in the case of Field's writing on the Soviet system, there are suggestions of a pro-market agenda that might perhaps cloud one's assessment. Twigg (1999) is the first English-language article to investigate seriously the variable operation of the system in the regions – where the important developments and variations are taking shape. Mention should also be made of Raison (1996) writing in French, who also covers this regional variation, although as part of a broader discussion of health problems. Other notable but short recent English-language contributions are the articles of Sergei Shishkin (1998, 1999) in the *Croatian Medical Journal.* This thesis – which looks in detail at the development of health insurance in two different sites, and from the perspectives of the policy actors and implementers themselves – is very much adding to the knowledge of what is happening in Russia

The thesis does not seek to evaluate the effectiveness of the reforms in terms of health care. Evaluation would be deeply problematic – I have no medical expertise, and in any case, establishing changes in quality of care during economic disruption and real social breakdown, with the quality of medical practice in the Soviet Union itself poorly understood, would be a tall order. Instead it seeks first and foremost to establish what is happening and why. In using interview and newspaper sources, as well as Russian professional and academic literature, I seek to build up a picture of how the system is laid out in two regions, with indications of how it operates in the rest of Russia.

The thesis is divided broadly into two parts. In the first half I seek to look at the context of health reform in Russia. Chapter 3 considers the importance of the "transition"

period from state socialism for welfare states and for health in particular, both in terms of the impact on policy making and the impact on the well-being of the population. In Chapter 4 I consider the context of the Russian reforms of health care financing in an international perspective, seeking to understand why a certain reform model was chosen. In particular attention is paid to the manner in which initial reform in post-Soviet Russia appears to be disconnected from debates on reform in so-called "mature" health systems, and heavily influenced by neo-liberal discourse sponsored by international institutions. In Chapter 5 I consider the early reforms in health care that took place under the broad rubric of *perestroika*, and then in particular at the experiments in re-organisation that affected one of the two research sites, St. Petersburg. I then move on to establish how the insurance system was introduced, and how it operates in the two sites.

In the second half I consider in more detail the attitudes of and problems faced by the respondents, and seek to establish the validity of what they say through examination of reports from around Russia. In Chapter 6 I consider the views of those employed by regional and municipal government to administer health care and form policy. In particular I consider problems of governance in the new insurance system and in conditions of financial deficit. In chapter 7 I consider the representatives of the medical profession – the trade unions and medical associations – and try to shed light on why these institutions in the post-communist period continue to be weak, and on any future role for the official representatives of medical workers. In chapter 8 I consider the two insurance institutions created by the new system – insurance medical organisations, charged with administering insurance money and enforcing higher and more efficient standards of care in health care institutions, and the territorial funds which gather contributions and equalise them across a region, and which guarantee the stability of the system. This chapter examines in particular the dynamics between the two organisations, and explores what may have led to the dramatic variation in health systems across Russia. Chapter 9 takes arguments from the previous three chapters regarding the implementation and operation of insurance, and seeks to establish their validity across Russia using various data sets and qualitative sources. In particular I use the classification of the regional insurance systems in Russia as used by Kravchenko (1996; 1998) and Raison (1998).

Throughout this thesis three key ideas dominate – the problems created by decentralisation, the problems created by the continuing economic crisis, and the attempts of policy-makers and institutional actors to adapt to these problems within what is a very broad legal framework. Aside from the detail of reform, the key contribution to be made is to examine the dynamics of change. Russian medical insurance reform has followed a

rationalist path of policy formation and implementation. The incremental changes that are happening now in the regions following the "big-bang" of the introduction of insurance are of greater significance than the law itself. It is these developments that this thesis considers.

2. Methodology and Research Design

In this chapter I consider the development of the research aims, the selection of data gathering methods and analysis, issues in health policy research and some comments regarding operating as a researcher in a foreign country.

The focus of the research and evolution into final aims

The focus of the research was originally "marketisation" in general, and a concern that social policy reform in post-Soviet Russia was following a pattern dominated by a neo-liberal Thatcherite discourse in the guise of received wisdom. This had much in common with ideas pursued by Bob Deacon (Deacon and Hulse 1997) and others in examining the "globalisation" of social policy, and of Guy Standing's (1996) concern about social policy experimentation in former communist countries. Although one may argue that, as in many East European countries this liberal policy failed to materialise, despite much rhetoric (Ringold 1999; Götting 1998), the rhetoric was enough to prompt interest and concern.

Originally I had proposed to consider the pension and health systems together. These both had been the subject of no little liberal attention, especially from reformers within the Russian finance ministry. As well as introducing health insurance partly as a path to marketisation, the Russian government had also at various times talked of moving toward the Chilean model of pensions[1]. In particular this sort of proposal is to a certain extent talismanic in neo-liberal discourses of individualisation and privatisation of welfare, and is typical of international agency advice to client countries in the 1990s. Overall there appeared to be a tension in policy between adopting European social insurance and US-sponsored welfare privatisation. In particular I was interested in the distinctions that would be made by Russians between the values embodied in the idea of markets and of social insurance: to what extent are the notions of individual choice and self-reliance (the freedom to enrich oneself and also the freedom to fail in that project) in conflict with notions of social solidarity? A comparison of the two areas of social policy would be interesting because of the differing levels of decentralisation (with health more decentralised). Part of the interview schedule eventually used covers issues of equality, access and choice.

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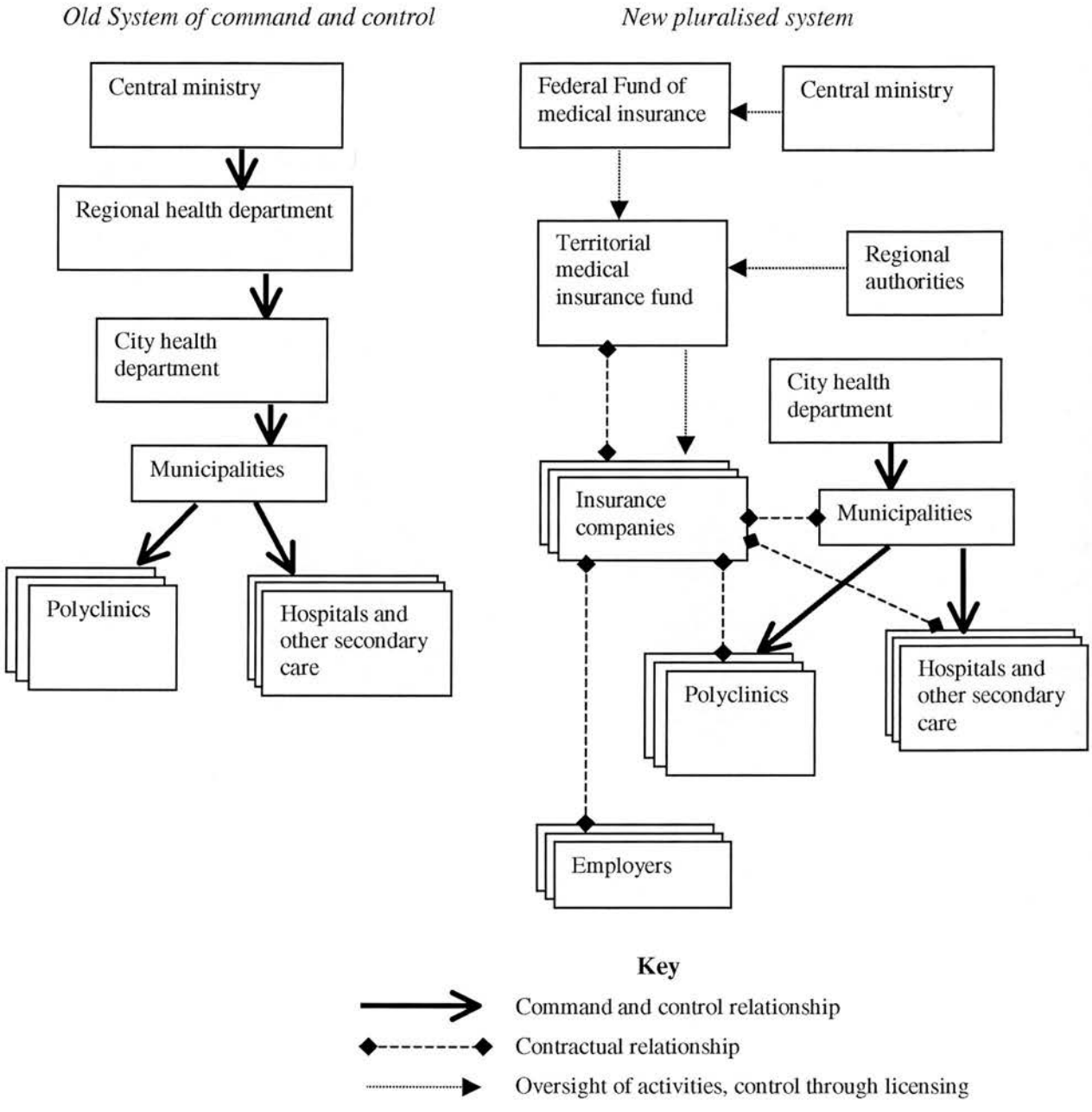
[1] This "pillar" system envisages a minimal role for the state in pension provision, relying on a mixture of subsistence state pension (both means-tested and social insurance), an occupational pension and a private pension. This would help (in theory) to relieve some of the future demographic pressures by ensuring that most pensions were paid for over a lifetime by the recipients, rather than as a Pay As You Go scheme where current workers fund current pensioners. It would also provide large pension funds to invest in industry to help regenerate the post-Soviet Russian economy.

The decision to focus on health was made at the end of the first year of the PhD. The reasons for choosing health over pensions were that the health system offered a greater level of possible variety between the two sites because of the greater level of decentralisation. This approach has been thoroughly justified. Although at that time (1997) very little material had been published in English regarding health care in the regions, it subsequently became clear both in the interviews and especially in Russian academic and news sources that the break with central control, and the confusing diversity of models of health insurance were major causes for concern. What was also appealing about health is my own more ambiguous feelings regarding marketising health systems; my previous postgraduate study of British health service reforms from 1989 onwards under the Conservatives had challenged my social democratic instinctive support for the pure national health model, common to many who study social policy in the UK.

Once the data were gathered, a new aspect of marketisation became more interesting, and it seemed more immediately important to the respondents than vaguer considerations of social rights to health care. In my funding proposal I had stressed the importance of covering what it was the Russians were talking about, rather than what many in the West are concerned with. Marketisation is not simply the attempt to bring out new ideas of social desert and right. It is also the installation of a new form of governance. Instead of a command and control structure with major decisions emanating only from the centre, the new health system proposed a pluralised system of contractual relations between providers, a system of purchasers and employers (see figure 2.1, next page). It not only upsets lines of authority (the break with the centre has been particularly striking) but also tries to introduce more co-operative relationships to supersede decisions handed down from above and based upon plans. In particular there are new oversight functions in monitoring health care and regulating an insurance system. For a number of reasons considered in chapters 3, 6 and 8, such relationships are both new and problematic in the early post-Soviet context.

In interviews, I gathered most material on the relationships between decision-making bodies, administrators, insurance bodies and representative interest organisations. The primary reason for this was that these questions came first in the interview schedule (being more concrete issues that allowed them to vent more immediate opinions and /or spleens). I had been warned by one supervisor (Mary Buckley) that Russians in an interview context such as mine were likely to talk extensively in answer to most questions. As a result of her prediction coming true, I had the most complete data in terms of respondents regarding these

Figure 2.1 A stylised comparison of old (pre-1988) and new (post-1993) governance systems in municipal health care in Russia



Note: these two diagrams do not attempt to depict resource flows.

questions of governance. Fortunately most arguments about health insurance across Russia emerge regarding the relationships between the actors – the regional institutional variation (many regions, for example, have no health insurance companies), the complexity created by a plurality of actors and the weak governance over the health system following local

government reform. In dealing with the results of the interviews, the focus on the governance and organisation of the system became central. My subsequent use of *Meditsinskaya Gazeta*, where articles by and interviews with the participants in compulsory health insurance and the representatives of medical workers, helped to strengthen this focus.

In retrospect, this shift from a focus on the wisdom of markets in Russian health care to the governance and operation of the current system is to be recommended insofar as it has assisted in avoiding the kinds of question that Burger, Field and Twigg (1998) put: is Russian health care "ready" for markets? "Marketisation" is an abstract that seeks to characterise a variety of tendencies. As I discuss in chapter 3, there is a danger that, in looking at such concepts as "market" or "democracy", we forget that they are intensely value-laden attempts to describe a collection of human behaviours and values, rather than ascriptions to some naturally occurring phenomenon, such as rain or cancer. It is of course important to take account of the importance of concepts such as markets in the drive to reform (and many respondents talked of health care reform as a necessary part of moving to "market relations"), and it is a fair characterisation of the Russian health reforms that they are "marketising" to some degree. However, holding Russian reforms up to some archetype of market relations and then asking if it would be any good for them if they ever got there seems a little misplaced. Firstly, as I argue in chapter 4, public health care systems assume various aspects of markets ("internal" markets, heavily circumscribed choice of insurer, heavily regulated and cross-subsidised contribution rate competition) to control costs and improve quality. But this is different to "marketising" in general. "Marketisation" in that sense is a broad idea that has obviously generated change. However it is one of the arguments of this thesis that the push towards a general state of "marketisation" led to the federal centre in Russia handing down to the regions an extremely vague law. Part of the unevenness in regional development that concerns Burger et al (1998) is therefore an indirect result of "marketisation" drives.

And so, the sites and subject of the research were originally identified and then more detailed research questions evolved. It is inevitable in any piece of research as initially inchoate as most PhDs are that the end product arises from the analysis of a wide variety of material that has been gathered for a wide variety of constantly mutating reasons. What becomes important is not the coherence of actions and work over the whole period of time, but the cogency and validity of the final analysis presented and of the conclusions drawn. I am confident that despite the changing focus over the first four years of this thesis, the arguments presented here are coherently based upon valid data.

The Research Questions and the choice of data gathering techniques

In investigating the original broad subject matter of market relations, there were a number of questions that seemed important to answer. First and foremost *what has happened?* As stated above, there were few adequate English-language descriptions of the new insurance system. While there had been what in hindsight appears to be a good albeit brief descriptive account of the system in St. Petersburg (Curtis et al., 1995), how this system related to the Russian federal law, or to wider problems across Russia (for example, Izvestiya 1995a&b) was simply not clear. Indeed, before undertaking fieldwork, it seemed unclear even whether some of the accounts were accurate, such was their variety and disagreement with the law as stated. Even now, eight years after the insurance system was due to be properly operational in 1994, there are few accounts of how the health insurance system works across Russia (*i.e.* appreciating the strong regional difference), and the best all by one person – Judyth Twigg, (see, for example 1999; 2001). Far more work on health in Russia has been concerned with the demographic crisis, with only oblique references to the new models of financing and organisation.

Indeed, many early writers had fallen foul of what Kroneman and van der Zee (1997) call the "fuzziness" of health reform – that in reading literature and information on health reform (for them from an international perspective) there are certain pitfalls to be avoided in establishing "the facts". It is no hyperbole to suggest their article should be made compulsory reading for anyone student starting into international health care reform, or for that matter other comparative policy areas too. In attempting comparison of health systems in terms of hospital utilisation, budgeting and planning, they discovered that authoritative sources often contradicted each other, and that national official documents often did little to clear up the confusion by stating more concrete events and schedules. They identified three main sources of "fuzziness" in health policy, all of which apply to the Russian case, and writers on Russia.

Mistakes, errors and misunderstandings occur when authors are either unaware of changes, or they misunderstand the implementation schedule. To be clear: Russia passed a law on medical insurance in June of 1991, planning for the introduction of health insurance at the regional level in 1993. After some amendments in the first half of 1993, the territorial funds in many (in principle it should have been all) regions began collecting contributions. Payment for health through insurance would begin in 1994. (Issues were complicated by a few regions introducing or moving towards their own model of insurance earlier, which was subsequently superseded, others implementing a variation of the federal model later). As a result in a variety of texts one could encounter three different dates for the introduction of

health insurance across Russia – 1991 ("enacted" – Curtis *et al*, 1995), 1993 or 1994. Shapiro (1997) for example speculatively attributes stabilisation of health funding in 1993 to the new insurance system. Many talk of "beginning" in 1993 (*e.g.* Tulchinsky and Varavikova 1996), without explaining what that means. Other mistakes are more elementary. Lloyd (1998: 316) appears to confuse marketisation of the health service with "privatisation".

Regionalisation also causes difficulties. Many countries decentralise responsibility for health care to the regional level. In Russia this results in two different phenomena. Firstly there is the tendency to generalise from one region to the rest of Russia. In my early research into this field, the difficulty was not so much that the authors themselves had not been clear that what they were describing was a model specific to the region they were discussing (*e.g.* Sheiman 1995; Curtis *et al* 1997), but that the extent to which other regions were not following that model was not made clear. It did not help that these authors and also Isakova et al (1995) tended to focus on two particular regions more than others – St. Petersburg and Kemerovo Oblast'. Their participation in earlier health care reorganisations had created for them a different path dependency to most other regions, most notably in the formation of "territorial medical associations", akin to the Primary Care Groups and Trusts now appearing in the UK.

Vaguely defined national policies applies to a variety of cases. The *phasing and adapting* of health and other reforms means that reform processes are interruptible. Kroneman and van der Zee give the classic example of the Dekker reforms in the Netherlands, the implementation of which was permanently tomorrow. In Russia we see this in health with Twigg (1992) asserting that insurance will begin in January 1993 "at the very latest", and also with long-delayed pension reforms (Vilenskii and Domina 1999). This problem also promotes the illusion that the early reforming regions are models for the rest. Mention of territorial insurance fund filial organisations providing insurance in place of the independent insurance medical organisations (a supposedly temporary measure permitted from 1994 to ensure 100% coverage in the absence of enough suitable IMOs) is not made in the English literature until Duffy (1997). The use of *framework legislation* at the national level is also problematic insofar as the details of the system can be hidden away in decrees. This is certainly the case with the Russian health system; many fairly significant developments have been at the behest of the Federal Compulsory Medical Insurance Fund, through bilateral agreements with each region, various "letters" and licensing decisions. Framework legislation also faces different implementation difficulties, especially those connected with regional levels of government. Thus Sinuraya (2000) declares from

consulting legal texts that there are 89 territorial funds gathering contributions and dispensing money to insurance companies, one for each region. There are only 88; federal law on this issue has yet to permeate Chechnya. More importantly, the variation in the operation of these funds is hidden by such statements; in six regions in the 1990s the funds have effectively operated as one of the finance departments of the regional administration.

Foreshadowing the future occurs where various actors take action in anticipation of a law being passed. A good example in Russia is the formation of Territorial Medical Associations (TMOs) in anticipation of the Russian internal market reform experiments of the late 1980s being broadened to all regions, and to being the basis of organisation within the health service, even under insurance. Sheiman (1995) and Curtis *et al* (1995) in particular give the impression that organisations in St. Petersburg and Kemerovo Oblast' would spread. In reality, the reforms initiated in these two regions and what is now Samara Oblast' were never properly implemented elsewhere. Indeed, in St. Petersburg many TMOs have broken up.

Deliberate vagueness in order to create broad support or in other words: governing by magic and managing by speech (Kroneman and van der Zee 1997:143) is particularly appropriate for Russia. Many authors cite the Russian constitutional guarantee of free health care as if it actually had force, when regionalisation of health care responsibility has frustrated attempts to enforce this guarantee in the face of charging (Kommersant Daily 1995). More particularly, the various federal laws on health protection of the population are also, in effect declarative: the fiscal crisis at the local level and the fragmented control structures over health care units (see chapter 6 especially) make any federal law guaranteeing free health care problematic. In both research sites, respondents talked seriously about introducing general charging for health.

So one of the main tasks of this thesis is to give an account of the extent of variation in health care possible between two regions in Russia that extends beyond formal institutional description and tries to establish the dynamics of health care reform.

The second task was to see, in each site, what policy actors *thought* about the medical insurance reforms. While there is much consideration of the wisdom of introducing health insurance, both in general and in Russia specifically, I was particularly interested in the opinions of the policy actors themselves who had been handed this law. How far had it helped them achieve their goals (and what were those goals)? Such material was missing in the literature. I should point out at this stage that at no point was I attempting thoroughly to assess more objectively the success of the health system in terms of improved treatments or more efficient use of resources. While this is an interesting question, it would require more

resources and time than I could command. Nor was I attempting to measure patient satisfaction. Instead I wanted to gather their views on the contribution of health insurance (and other interlocking elements of Post-Soviet reform in health and governance) to running a health service. Part of this does involve a measurement of success: King (1987) makes the point that measuring the success of Thatcherism is not entirely a matter of looking at subsequent economic and social indicators, but also looking at how far the principles of social organisation have been re-oriented to the individual, and wider economic choices have become available to people. Similarly, health insurance was introduced on certain ideological as well as simple efficiency grounds: the desire to get people to care about their own health, the need to incentivise doctors, the need to introduce choice and allow initiative and responsibility. What was also interesting in planning the research was whether there was resistance on the part of individuals within the system on the grounds of their opposition to liberalisation – an allegation made by Shishkin (1995).

Some aspects of this question I abandoned during the interview process as it became clear that there was enough to be said purely in terms of governance issues and opportunities. In particular, questions regarding the level of contributions and the meaning of insurance contributions were quickly abandoned as too unwieldy and also, the first couple of respondents felt, outside their remit. Other questions – such as the issues of broadening choice for the patient, often returned more legalistic rather than ethical answers. In practical terms it became clear that the interview schedule was too long for so many voluble respondents, and only partial data was gathered on the more abstract considerations of choice, fairness, access and efficiency (although more concrete aspects were of course raised elsewhere).

More research questions and the 'critical case' of St. Petersburg

A second important consideration for the research was uncovering variations between the sites that could be put down to two particular factors: the presence of reform-minded elected officials in local government and the experience of previous reform. It is this consideration that led to the selection of at least one of the sites. These two issues are concerned primarily with the *progress* of reform, in being able to overcome institutional difficulties in enacting health insurance. I became interested in them because of the currency these ideas tended to have in the media, and to a certain extent with the second, in academia. Great store on the part of international agencies and foreign governments had been put by the election of "reformers" as opposed to communists to positions of power in Russia. Lloyd (1997) accuses the International Monetary Fund (IMF) of intervening in the 1996 Presidential election to

secure Yel'tsin's victory over Zyuganov. This concern about reformers maintaining power seemed to reflect two notions: that reform needed leadership and a reform minded-electorate in order to succeed. Was this true in practical issues of importance to the population, such as health care? The ambiguity here is between reformers supposedly seeking to liberalise, with conservative/social democratic forces supposedly having greater concern for the good running of the health system and other social policy areas. It was also a common theme in many articles on the progress of former communist states in reforming their societies that those who had some more recent national memory of "capitalism" seem to make the best progress, or alternatively experienced some reform before the official fall of communism (for example, Duke and Grime, 1994). Notable among these is Hungary, which developed a great deal of property legislation from the 1970s onwards, and Poland, which experienced some privatisation in the 1980s. Could this be extended to the case of health care?

In seeking to answer these questions, I became interested through methodology studies in the notion of the "critical case". In doing case studies, one inevitably runs the risk of accusations of unrepresentativeness. In particular, St. Petersburg is unusual as a federal "region" of Russia insofar as, being (like Moscow) a city "of Federal Status", unlike other regions it has a unified administration; it began the transition period rather richer than most regions; and is characterised by some Russians as more 'European' than 'Russian'. However, the issue is not a case of statistical representativeness - a case study does not involve a "sample" of one, nor is it limited to producing knowledge about the specific case with which it deals. As Yin (1989) points out, if we ask a similar question "are experiments unrepresentative?" we see that the issue is not one of representativeness, but of suitability in examining the logical validity of certain propositions. Theories and hypotheses in social science go beyond statistical correlations to explanations of and causes for phenomena. If a theory does not obtain in a situation where one might expect it to, a case study allows us to investigate why not, or how the theory needs to be refined. Indeed, in choosing sites for cases, we are often not at all interested in random sampling, but in specific selection of a case for its properties - either because the case exhibits the best conditions for a theory to obtain (and so we may study the operation to establish and refine the theory - or if need be reject it) or because it is a "deviant" case, where the expected result according to a theory did not obtain (Hakim 1987). One can term this "theoretical representativeness". Given I was interested in testing hypotheses that were possibly more complex in their operation than would be revealed in statistical analysis (although some is attempted in this thesis in chapter 9), a critical case study seemed appropriate.

In choosing St Petersburg, I chose a "critical" case, where conditions within Russia appeared among the best for reforming health care finance. It has had substantial historical experience of reform of health care, both in the recent past (1988-1992), and further back. It is also one of the most consistently liberal reform minded regions in terms of its voting habits, having elected as its first mayor the outspoken liberal law professor Anatoly Sobchak[2], and producing the highest turnout for the non-Kremlin liberal Yabloko party. A second regional case was chosen in order to generate what Rose (1991) calls the "logic of comparison" – using multiple cases in order to test a variety of hypotheses. Volgograd Oblast', of course, is not a critical or deviant case. It did not participate in the initial internal market experiments, but nor was it sluggish in attempting the introduction of health insurance. Its electoral leanings are towards the communist (it is part of the so-called "red belt" that stretches from East of Moscow down through the Volga region), but not dramatically so. Furthermore, its imposed political leadership (many regional heads were appointed in the aftermath of the 1993 attempted coup) up until 1996 has been identified as reformist. It is not particularly poor, nor rich, nor intensely more agricultural than industrial. Unemployment is relatively low and the level of wages is near the Russian average (Tacis 1996 vol. 1). It is neither particularly dependent upon subsidies from the centre for its economy, nor is it a large donor to the centre (McAuley 1996) – issues which might affect regional governance and liberalisation (see, for example, Zhuravskaya 1998).

However, there is good reason for having attempted a comparison between a critical and a non-critical case. There can be in multiple case studies a kind of "replication logic" (Bryman, 1989). Trends in one case can be examined in another; if a phenomenon occurs both in the critical and the non-critical cases, one may suggest a broader thesis, or discount a thesis that largely depended on the idiosyncrasies of the critical case alone. Although at first blush there is a conflict between the logic of comparison and the logic of replication, in that the former emphasises differences and the latter similarities in the choice of cases to study, when there are overlapping or "shifting" cases (health care, two different sites), both comparison and replication are possible.

It could be argued that other regions could be studied in the place of Volgograd region. While this is true, there are two reasons why Volgograd is included in this study. The most important is convenience: it is where I lived, worked as an English teacher and studied for a year and a half. In doing the research I found the journalistic contacts I had made (through teaching them English) very useful in establishing facts and getting phone numbers

[2] He subsequently died of a heart attack in France, having fled Russia on charges of financial corruption after losing office.

(although there was nothing as comprehensive as the invaluable *Who's Who in St. Petersburg Medicine* to aid me). Moreover I had already had an assessment by figures in the regional government (whose children I had taught) that getting access to people shouldn't be a significant problem – which calms the nerves of a rookie no end. Secondly, the region, like St. Petersburg, elected a new regional head in 1996, who although nominally independent, was elected against the semi-official liberal "reform" candidate. Comparisons could then be made of the "before and after" regimes in each site.

Data sources and collection methods

Given that I was exploring an under-researched area (and hence was unsure what was of importance to those operating within the new system), that I was keen to "give voice" to participants in the system, while attempting to maintain a focus upon health insurance, semi-structured interviews were the obvious choice of data collection methods.

The respondents (listed in full in appendix II) that I wished to talk to were reasonably obvious: those in charge of health care at different levels of regional government, those working for the regional funds, representatives of those working in insurance companies, representatives of the medical profession, as well as anyone who I felt could contribute information – notably a journalist in each site. Only two interviews arose out of a referral – with the head of the first insurance company in St. Petersburg and the head of the health care organisation department of Volgograd Medical Academy. In all 34 interviews were undertaken, ranging from thirty minutes to four hours: 14 heads of local (rayon-level) health care and the head of health care in Volzhskii, Volgograd Oblast'; the heads in each region of the medical association and of the medical workers trade union; the chair of the head doctors association in St. Petersburg; with representatives of each insurance medical organisation association; as well as the head of a municipal insurance company in Volzhskii, and the aforementioned innovator in insurance in Petersburg; representatives of from the territorial insurance funds, the head of the health care organisation department in Volgograd Medical Academy; with representatives of the city health care committee in both sites, and also the Oblast' committee in Volgograd; with the deputy mayor of Volgograd (one of the so called "fathers" of Volgograd insurance), the editor of *Meditsina Peterburga* and the Volgograd regional correspondent of *Meditsinskaya Gazeta*; with the head of the St. Petersburg assembly health care commission. I also took a "vox pop" of health care trade union participants in protests in St. Petersburg on November 7.

What would have added to the interview material would have been interviews with actors in Moscow, notably members of the health care committee there. However, my

schedule for being in Moscow unwittingly coincided with a "regional" break in the state Duma, a week where deputies return to their constituencies, and no interviews were possible.

The interview schedule was drawn up in English, and translated into Russian with the help of Ivan Boitsov, a lecturer at St. Petersburg State University in Russian as a Foreign Language. All interviews were tape recorded with the exception of one refusal to be recorded, one where most of the interview took place before I was allowed to start the recording (for reasons, I feel, of eccentricity rather than secrecy) and two others where recording was not possible for practical reasons (with the two journalists). Some interviews ended after I had run out of cassettes (including one that had gone through 3 hours of tape already), and had to be summarised thereafter also.

The other significant source of "deep" material was *Meditsinskaya Gazeta*, the national newspaper for the medical profession. This is a twice-weekly tabloid-sized publication that contains a variety of articles (some by journalists, some by individuals involved in health care) as well as interviews with a variety of actors, especially at the regional and local level. It contains articles supportive and critical of insurance and of reforms in general, as well as being a conduit for ministerial speeches and some normative documents. A variety of respondents whom I asked felt that there was no bias in the editorial policy, although mild claims had been made on its own pages regarding the treatment of trade unions in the early 1990s.

I had not been aware of its significance as a source of information until travelling to Russia. It is a resource that was sparingly used in the articles on Russian health in the mid 1990s; the Russian writers did not always source material, and many English ones did not make use of much Russian-language material. At Birmingham University I trawled through every single issue from 1987 until 1998, collecting material on a wide range of areas, generating around 1500 articles for consideration. The selection of material was undertaken after the interviews had been taken. This allowed me to consider issues I had not considered as important or interesting before, notably material on the representative associations, and on more general questions of governance. It also allowed me to "triangulate" the interview data – to assess the typicality of the material I was gathering, both in the research sites and across the rest of Russia. Similar use has been made of articles in the journals *Zdravookhranenie* ("health care") and *Ekonomika Zdravookhraneniya*. In general I made use of Russian language material available at the universities of Glasgow, Birmingham and also the Library of the Russian Academy of Sciences in St. Petersburg.

Statistical data has been used from a variety of articles. In particular I have made use of Federal Compulsory Medical Insurance Fund data as published by its employees (notably

Nataliya Kravchenko), Goskomstat (state statistical committee) socio-demographic information available on the internet, and Tacis information on the development of Russian regions (Tacis 1996). Much of this data has been employed in chapter 9, where I seek to examine patterns across Russia.

Interview Access

There were few problems in getting access to those I wished to speak to. In all cases the procedure was to get hold of their work phone number and call them – which usually involved contacting their secretary first. Interviews were normally arranged two to three days in advance; respondents in general were not keen to organise meetings much further ahead. Only one respondent refused outright, explaining that he only talked to journalists he knew. As reported above, only one other did not wish to be recorded (it was, perhaps not by chance, the most anodyne interview as well, consisting of his pointing to various chapters in the *Conception* document in St. Petersburg to express his opinions). In two cases there were insurmountable difficulties in getting past secretaries. In one instance I was bounced back and forth from the international department to the antechamber of the insurance specialist at St. Petersburg Medical University to no avail. In the second instance arranging an interview with the head doctor at the main regional hospital in Volgograd Oblast' proved absolutely impossible due to the secretary there, despite other officials within the hospital having validated my application for an interview.

At first, as I pursued interviews with St. Petersburg municipal health care chiefs, there was a certain reluctance to agree to be interviewed. It appears to have been in part a question of status. I had been describing myself as doing a *Kandidat* degree – which is normally translated into "PhD", especially on business cards. In discussion with a Russian teacher at St. Petersburg University, it was suggested I say I was doing a *Doktorat.* Kandidat degrees, it appears, are probably more akin to MPhil degrees. They take three years (but no more), and there is far less consideration of it as a piece of original research based on new or newly considered data (although it is to a very high level of understanding). A *Doktorat* on the other hand to a Russian is awarded normally for a piece of work done after ten or fifteen years of academic life. Keen to avoid misleading respondents, I was a little wary of this approach. However it was impressed upon me that technically speaking I would be absolutely correct. *Kandidaty* are not called "Doctor", but I would be. I have since confirmed the fairness of the attribution of *doktorat* to a British PhD with other Russians and post-Soviets. This was hardly walking the tightrope of covert research. But perhaps having gone

bald at a relatively young age aided this non-deception when I appeared to take interviews. In any case, interviews were granted far more immediately.

Anonymity

Many respondents were keen to know that I would not be publishing in Russian newspapers or sources, a fact of which I could assure them. I promised anonymity where possible and appropriate. In terms of the health care administrators in St. Petersburg and Volgograd, this has been fairly straightforward. I have also used their roles to label their quotations. For those officials in more unique positions it was made clear that there would be more difficulty in achieving anonymity, but any contentious material would of course be dealt with more sensitively. It has to be remembered that in the interviews, much of what was told to me is also the respondents' public position, aired in front of their colleagues, and none certainly out of the ordinary considering open media discussion within the health care sector.

Doing research as a foreigner and in a foreign language

It is a commonplace that outsiders coming into a research site will often get better access to the more darker details and enmities, because, as an outsider, they are not viewed with suspicion, or not seen to be as partisan. To be honest I would say only in a couple of interviews did I feel I was being told of details or opinions that might not have been revealed to a Russian researcher. Instead at times I found it necessary to demonstrate my knowledge of the health insurance system, or to explain the reasons for asking questions in order to establish my credentials. A good example of this is the change in tone and character of interviews in Petersburg with some respondents when it became clear I had both heard of and read the City Government document *Conception of Development in Health Care 1998-2003*.

There were few language difficulties. I had learnt Russian to a fairly high level while living in Volgograd 1995-6. However, I chose to spend a month in St. Petersburg before beginning interviews trying to refresh and improve my language skills at the state university (lessons which I continued when possible throughout the research, using the opportunity to sit the state Russian exams in March 1999). The material dealt with here is not of a troubling complexity or subtlety in terms of language comprehension. I am not indulging in critical analysis. In transcribing interviews I was pleasantly surprised at how few supplementary questions I failed to ask. It should be stressed that the bias in my Russian skills is towards the academic rather than the literary; talking philosophy or health care reform comes more easily than discussing the qualities of last night's film on TV. Occasionally on bad days I

experienced "grammar failure" where the words would not come out and certainly not in the right case or agreement; fortunately this does not seem to have affected the quality of the material once I had made my question understood. The volubility of respondents also helped.

The chief difficulty in interviewing was the opposite of my experiences of the interview training I had received in the UK. In Edinburgh doing practice interviews had been a struggle to get my respondent (another student) to talk at great length. However in Russia, the respondents all seemed delighted to be given the opportunity to talk at great length; it was of great value that I knew my interview schedule well enough to skip around where necessary, where they had either answered questions already, or were straying strongly in that direction. There is also a great danger, as I had been warned, of asking people to talk about their background before they took up their present position. On occasion I received family histories going back two generations.

Time and circumstance

There is one major issue of timing that ought to be considered as having a possible effect on the data. Firstly, as I was about to start doing interviews in August 1998, the rouble crashed, losing 75% of its value. This delayed the interviews by around three weeks, as understandably respondents were too busy coping with the sudden fiscal crisis. One might argue that this would prompt the respondents to dwell upon financial issues to the exclusion of everything else. However there are three important issues to remember. Firstly, the decline in revenues particularly in Volgograd had been occurring from before the crash; the crash itself was a symptom of poor economic performance. Finances had been a serious problem since the introduction of insurance. Indeed, in terms of finances, no one talked about the period before the crash as being particularly rosier. Instead from around 1995-6 onwards they reflect upon increasing financial problems. Secondly, the crash itself seems not to have precipitated a major slump. Indeed, although the headline collapse in the rouble is shocking, there is evidence to suggest that in the short-medium term it boosted the real economy by promoting domestic production. Thirdly, the health sector itself tends to depend upon domestic pharmaceuticals, whose production had been in crisis for a couple of years before. Certainly, there is little difference in what respondents were saying to me in the months after the crash and what people in similar positions across Russia were saying in the pages of *Meditsinskaya Gazeta.*

Data analysis

The interviews were analysed initially according to the category of respondent, beginning with the territorial fund and insurance company representatives. This had the advantage of

dealing with only a few transcripts at first (making cross-referencing obviously easier) as well as providing a more direct focus on the operation of insurance rather than problems in health care in general. Other transcripts were then consulted for references to the main issues raised by the insurance actors. This process was repeated for the professional representatives (again, a smaller number of interviews), and then finally the administrators, who took up half the interviews.

This process of familiarisation with the interviews was helped by the volubility of the respondents on some common general topics that stood out: problems created by shortages in finance, in Volgograd Oblast' conflict between regional and local government, the competence of the insurance companies and the territorial funds, the moral and physical health of the population and of those in positions of responsibility. Although the interview schedule (Appendix III) is six pages long, a majority of the interviews did not get that far. Several interviews were half an hour old before respondents had finished with their opening piece on the problems in insurance and I could begin with the schedule.

Specialised computer software was not used for interview analysis (statistical data in chapter 9 was manipulated using SPSS). This was done for two reasons. Firstly, the interviews were transcribed partly in Russian (Cyrillic) and partly in English (occasional translation difficulties, colloquialisms necessitated this); computer packages available to me could not handle this. Secondly, the only data package available to me on my own portable computer was an old copy of Ethnograph; this is rather akin to electronic pencil and paper, with the disadvantage of not being able to look at more than one piece of paper at a time. The nature of the interview analysis (done according to respondent role) also meant that the available time efficiencies of using a computer package for each area were rather limited. It is also probably the case that the training I had undertaken in data analysis had not revealed all the benefits of some of the more advanced qualitative data computer packages.

Instead coding was achieved by going through interview transcripts, copying (rather than cutting) and pasting any quotations within the dominant themes or organisation of interest (tagged with their owner) into new documents. These quotations were then organised into what seemed to be the most sensible divisions, and then organised into chapters.

Ultimately, the task became a matter of how to organise the material thematically. The most important aspect for me was what concerned the respondents – what issues (and whom) were they facing that made their lives harder (and occasionally easier) – rather than seeking to incorporate their responses into a theoretical model. I remained with organising it according to respondent type because the significant variations in what was dwelt on in interviews regarding these broad themes was a reflection of the tasks facing each individual. Fortunately the wide variety of complex practical issues provided enough points of general

consensus (or straightforward disagreement) to fill the thesis without conclusions having to ride roughshod over nuances of speech.

The chief "problem" of doing health policy research on Russia in the decade after the collapse of the Soviet Union has been the exponential growth in Russian material, not only from the centre but also from the regions, and in its availability over the internet. Initial broad information gathering strategies that were appropriate (feeding off scraps and hints in Moscow newspapers and generalist articles) gave way to trying to organise a mass of material produced by a large population in a vast country. Indeed, the natural desire to "do just a bit more" of most PhD students was unhelpfully compounded by the broadening confection of available information, anecdotes and polemics from different parts of Russia. It is a country whose diversity, contrasts and size makes ideal terrain for social researchers. I would heartily recommend anyone considering research there to go for it.

3. Transition and Social Policy

Developments in the Health Service in Russia are directly related to the overall "transition" from communism to capitalism. The dominant strands of the transformation – the economic, political, and ideological – have impacted upon social provision through changing the resources available, modes of organisation and approaches to social justice. Moreover the changes have affected the wealth and welfare of the population – and in Russia over the first ten years, notably for the worse.

Separating out the strands of transition is problematic. The temptation is to separate too cleanly – providing an illusory sense of coherence and focus to the changes, and glossing over the contradictions between various "transition" tendencies. Conversely, as I shall argue, it has proved difficult for many analysts to separate the prescriptive and the descriptive, with the countries of Eastern Europe and especially Russia providing a theoretical battleground for analysts and policy advisors in the 1990s. (Indeed, the changes have exposed problems in some of the analytical methods, presumptions and understandings within both mainstream economics and political science). Correct description is important for proper action: the discourse of transition has, however, shaped and limited policy within narrow, albeit stark, boundaries, while actual processes of transformation have either implied or sought the emasculation of collective action and good governance. In particular, social policy priorities and development have been muffled by theoretical (economistic) approaches of those in government, while social policy problems have increased. Health services, embedded within economic and political processes (cf. Moran 1995) and interacting with – and indeed run by – a population experiencing these transformations, are especially exposed to changes (diminutions) in state capacity, in principles of distribution and modes of management, and in the well-being of the population.

In this chapter I seek to establish the impact of transition on social policy and on health services in particular. This is partly to provide an appropriate backdrop for the research, and an introduction to social policy in Russia; partly to make an important point about the potentialities and problems of social policy in post-communist Russia.

When did transition start?

The "transition" as it is most commonly talked about refers directly to the period following the collapse of Soviet communist power. This suggests that the most important single change was political, when those attempting liberalising reform to *preserve and strengthen* the Soviet Union were removed from power. However, this emphasis on the high political at the

expense of the social and the economic is misleading. As I shall argue below, the dominant reformist discourse in Russia has been economic, and often at the expense of political and institutional development. Economic and organisational reforms that led to marketisation plainly began before 1991. White (2000) calls the transition process "curious" (262) because for him it actually began under Mikhail Gorbachev in the latter half of the 1980s. Both elements of democratic and economic reform began at that time through the processes of *glasnost'* – openness – and *perestroika* – economic reconstruction. It is true that these reforms were then overtaken in dramatic fashion by the collapse of the Soviet Union and the full independence of the Russian Federation under the "reformist" Yel'tsin government. However, while the *perestroika*-era reform path was not *originally* meant to be leading towards the kind of economic liberalism that was the goal in the 1990s, by 1991 Gorbachev's cabinet had pledged "to promote in every way the development of effective forms of organizing the production of consumer goods and are to actively pursue a policy of destatization, demonopolisation and the development of entrepreneurship in this sphere. A market infrastructure is to be formed at an accelerated rate..." (Izvestiya 1991b). The smaller general "transition" begun under Gorbachev was thus a *developing* prelude to the reformist forces gathering throughout 1990 and 1991 as the Union began to collapse. There is *some* discontinuity between the economic policies sought by Gorbachev – encouraging and fostering a fair degree of private economic activity and initiative to improve consumer goods markets, and those sought by Yel'tsin – full liberal market capitalism. However, this difference can be exaggerated, and the before and after of transition can be portrayed too cleanly, if we simply look at the collapse of the USSR and the "independence" of Russia as our turning point.

Moreover in health care (and in the context of health care reform) it is arguable that radical reforms were taking place under Gorbachev, albeit experimentally in a few Russian regions. This paradox emerges partly out of the general inertia in social policy development at the centre in the Yel'tsin era (and common to most East-European countries after the collapse of communism (Elster et al 1998: 203)), partly out of the ideology of economic reform his governments more or less espoused, and partly as a side-effect of Gorbachev's own ideas for economic renewal. Indeed, given the inertia in social policy of the post-communist period, it is especially important to consider developments before 1991. I shall therefore briefly consider the nature of the general reforms in the second half of the 1980s as they relate to social policy and health care in particular.

As Gill and Markwick (2000) point out, the policies pursued by Gorbachev were not originally intended to bring about an end to communism, but to improve efficiency and

productivity. This was a key element in the approach of Gorbachev's patron and predecessor-but-one Yuri Andropov, who had focussed particularly on workplace discipline. The reforms were a natural development once the tinkering and tightening of Gorbachev's initial call to *uskorenie* (acceleration), aimed at increasing work effort largely through exhortation, and his anti-corruption and anti-alcohol campaigns had failed to yield significant results (and in the case of the latter had led to a rise in alcohol poisoning from home brewed spirits and much public resentment as well as a collapse in state revenues). Thus even Gorbachev's reforms have to be seen partly as a development of some of Andropov's and as a reaction to their failure. Gorbachev did not actually come into office as a trailblazing reformer[1], but became one quite rapidly once his more committed version of Andropovism came up against resistance. Thus we need to appreciate how the Gorbachev programme *evolved* and *developed* into one that led to the undermining of the leading role of the communist party and the introduction of commercial practices and private profit, as well as direct elections. Although it is possible to construct an argument that the introduction of *glasnost'* and *perestroika* would lead inevitably to the collapse of Soviet power, they were actually intended to renew the socialist system.

The strategies pursued by Gorbachev from 1986 onwards were of a piece – *glasnost'* was an adjunct to *perestroika*, allowing for public criticism of officials (especially those resistant to change) and the proper airing of difficulties so that solutions might be achieved more rationally. *Perestroika* itself sought to harness 'initiative' in resolving economic problems by encouraging greater freedom to manage at lower levels. Technological improvements were to be aided by gaining access to Western advances through dialogue and the creation of joint enterprises, requiring the USSR to become a more acceptable partner in terms of human rights – through the processes of democratisation sent in train by *glasnost'*.

The reforms produced a particular focus on social policy. As an early emphasis of his leadership, Gorbachev sought to raise general living standards, chiefly by directing economic production towards the consumer market and to the social well-being of Soviet citizens. Whilst boasting of its social achievements abroad, the USSR had actually achieved only a form of low-wage security. The introduction of an official minimum subsistence level in 1988 (by itself demonstrating a rather late attendance to social policy) showed that 32% of the population were poor, receiving less than 105 roubles a month – and that before the advent of significant price reform (Moskovskiye Novosti, 1991). While supposed improvements in the consumer sector were originally based on the declaration of raised

[1] Although Archie Brown has noted his unusually fast rise to the top at a young age marking him as a man to watch, while Margaret Thatcher declared "I like Mr Gorbachev. We can do business together"

planning targets without detailed plans (although this later became the main focus of Gorbachev's market reforms), in the social sector more immediate planned 150% increases in capital investment in schools and hospitals, and increased spending on housing in the 1985-90 and projected 1991-95 planning periods (Aganbegyan 1988) serve as evidence of a clear early commitment to improving social welfare. Gorbachev also wanted to tackle the historically low wages of those working in health and education (Hauslohner 1991). There was no immediate challenge to the orthodoxy of extensive health sector growth based on intermediate indicators of hospital, bed and doctor numbers[2]; greater changes came a couple of years later as *perestroika* methods of reorganisation began to infect the health service.

There were four key aspects of the Gorbachev era reforms that had the greatest impact on social provision and on health care particular. Firstly and most dramatically, in the increased public awareness and discussion of social and health problems – of the suppressed issues of drug abuse and prostitution (see for example, Buckley, 1993) as well as more open discussions of the quality of food and housing, and of the poor state of the nation's health. Just as in Western societies, behaviours that were commonly labelled as "deviant" were spreading in a society that had supposedly created the material conditions (the absence of capitalist exploitation) to eliminate them. Furthermore, the Soviet economy was failing to provide an adequate standard of living, including enough housing, as well as in many of the Southern republics not securing the full employment that it sought. In health and health care the statistics were striking. While the USSR laid claim to the highest number of doctors per head of population in the world, the outcomes in health were poor. Rises in life expectancy since the Second World War had stalled since 1970 and infant mortality lagged dramatically behind other developed nations[3]. In terms of public health and disease prevention, problems generated by poor sanitation such as cholera outbreaks (the news of which throughout the post-war period was suppressed) and inadequate sterilisation of equipment (two thirds of Hepatitis B cases in the 1980s were put down to infections during treatment and diagnosis) became far more widely known (Pravda 1990a; Izvestiya 1990a). The freedom that *glasnost'* gave to those wishing to air these points allowed more focussed debate on the problems within health care, and to remove the complacency that the Soviet industrial focus on extensive development had hidden.

Secondly, in making much easier the creation of organisations more or less independent of the state. Amongst these, as well as groups that articulated the interests of

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in 1984 - before he reached the highest office.

[2] For a greater discussion of problems within the Soviet healthcare system, see chapters 4 and 5.

certain groups or cultural (and often covertly political) persuasions, there were those aiming to meet the welfare needs that the state itself was failing to, allowing for the development of some kind of genuine[4] voluntary sector (see for example, Anne White's seminal 1993 article on the *miloserdie* movement). As with the openness in social issues mentioned above, these changes received impetus, amongst other crises, from the nuclear disaster at the Chernobyl' reactor in the Ukrainian SSR. The desire of officials to cover up a major catastrophe provoked the pursuit of critical openness; the activities of the Red Cross in providing substantial aid raised the legitimacy of independent charities (White, 1993: 790). However, many new independent organisations (including at least one doctors' trade union in Vladimir) often ran into difficulty with more conservative local officials. Although the Soviet constitution allowed freedom of organisation, 'superfluous' organisations were not allowed: the legitimate existence of a non-state organisation implied that the state itself was not successfully fulfilling its duties. Thus the ability to grant licenses to these new organisations became a battleground for those for and against the *perestroika* programme – those who accepted the new critique of the Soviet system and those who didn't.

Thirdly, as part of the intention to introduce greater initiative from below, certain market-style mechanisms were introduced into the Soviet economy. This was a change in direction from the initial centralising tendencies of *uskorenie* and increasing workplace discipline. Instead of detailed plans being handed out to enterprises, there were general targets over a longer period of time. Enterprises were to fulfil orders mainly according to demand, although a large part of demand would take the form of orders from the state (Rutland, 1990). Furthermore, there was to be a general move towards self-financing in one form or another, whereby organisations were meant to set prices in their exchanges with one another that covered their costs and allowed for an investment fund to improve facilities. These reforms may be called "market-style" because they introduced the notion of prices that reflect cost and output determined by supply and demand. Production was thus established horizontally, rather than vertically through supposedly scientific economic planning by Union and Republic ministries. As examined in chapter 5, a special *perestroika* experiment introducing, effectively, an internal market in health care was undertaken in three areas of the Russian SFSR, including Leningrad (St. Petersburg) in 1988. General self-financing was in principle extended to health care institutions across the Soviet Union in 1989-90, although in practice this was not done in many regions by the time of the collapse of Soviet authority.

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[3] It is noted here as elsewhere that high adult mortality rates are only marginally affected by direct provision of health care; the point at issue here is the focus on success and the concealment of failure in health. Infant mortality is more closely related to health care quality.

In addition, laws were passed in 1987 and 1988[5] that allowed, under licence (later merely 'permission'), individuals and groups to earn income outside the state planned economy[6]. The co-operative movement that grew out of this was supposed to increase labour inputs into the economy through introducing better incentives, and to improve responsiveness to shortfalls created through faults in the central planning process. In social policy in general this presaged the possibility of increasing income inequalities as those in co-operatives could increase their incomes dramatically, with significance both for social security and health. It also allowed for entrepreneurship in the social sector. In the health sector in particular the development of co-operatives of health care providers provoked no small controversy – a matter I shall consider in chapter 5.

Lastly, but significantly, throughout 1990 and 1991, as part of a full admission of the desire to move towards some kind of market economy, social insurance laws were prepared (and some passed) covering pensions, health, unemployment and industrial accidents, reflecting Gorbachev's more social democratic intentions. These plans also represented part of the changing balance of power between the union and the republics (particularly Russia under Yel'tsin), and the opening up of the Soviet Union to international institutions who might offer funds for reconstruction in return for Western-style reform. However, their passage and enactment took place under conditions of Russian independence from the Union. From the point of view of *Perestroika*, they were an attempt to raise expenditure on social welfare. From the point of view of the new reformist government, they were the foundation of more radical reform plans.

The collapse of communism and the start of 'Transition'

The forces and conflicts that led to the collapse of Soviet power are of course not an immediate concern for this dissertation. What is important is the legacy – an economy that by 1990 was experiencing serious shortages and suppressed inflation as the *perestroika* reforms failed to work; a vibrant awareness of the social problems accumulated in the previous two decades; a short and localised experience of institutional innovation, including the healthcare sector, and the initial beginnings of independent interest organisations and welfare groups. However against this we must weigh the more ingrained experience not only of a highly centralised command economy organised through plan and *diktat*, but also of

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[4] Official volunteering had been in place for decades – unpaid work by the pioneers, by the *subbotniki* (working unpaid on Saturdays) and so on. But here "volunteer" is used in its Orwellian sense.
[5] Law on Individual Labour Activity 1987, Law on Co-operatives 1988.
[6] Various permitted, tolerated and illegal forms of earning private income had existed previously, especially in agriculture and construction, although general prohibitions on private enterprise left them vulnerable to arbitrary control by local enforcement authorities. See Åslund, 1991, ch. 6)

Brezhnevite stagnation, with chronic misallocation of resources resulting in shortages, and of suppressed non-state organisation, (commonly known as civil society) and a population that was poor and increasingly unwell.

"Transition" as a world view

Although the previous discussion establishes that economic and political liberalisation began under Gorbachev, the beginning of the "transition" as it is generally understood started in 1991. The pursuit of a social-democratic Soviet Union finally gave way to the attempts at liberalisation of "Gaidar and his gang", under the leadership of the democratic nationalist Boris Yeltsin. The Communist Party was suspended in August and outlawed in November, its property confiscated. Prices were liberalised on January 2 and by February 1992 the Russian government had gone so far as to submit a memorandum to the monetarist IMF. The period of "reform" had begun. The changes envisaged and propagandised were dramatic (as was the impact on the well-being of the population, as discussed below). Naturally there arose consciousness of "reform" and "transition" (indeed, in chapter 9 the division between reformer and conservative is used as an object of statistical analysis). Many respondents demonstrated express consciousness of the notion of "transition" and how it impacted upon developments in health care. Some respondents themselves used the word *perekhod*, transition (*etym.* "a crossing over") or adjectivally *perekhodnyi period*, and it is a term used in Russian political debate. (There is even an *Institut Ekonomiki Perekhodnogo Perioda* in Moscow, founded in 1990 and now headed by ex-premier Gaidar.). Often they made a direct connection between attempts to re-organise the structure and financing of the Soviet health system and the general re-organisation of society. In the following brief section I seek to explore the significance of "transition consciousness" and its impact on attempts to change methods of governance in health care, as well as illustrating the manner in which many respondents talked – to give a flavour of the discourse.

Transition, *in principle*, consisted primarily of two things – "democratisation" and the creation of a market economy. It is a commonplace to point out that economics is not as objective and value-free a discipline as some of its practitioners are wont to pretend. What is also worth considering is how moving to what many of the research respondents described as "market relations" implies changes in personal relations, in motivations to work, in perceptions of the common good and what should be held in common, in life chances and the rationalisation of good and bad fortune. It is, to a degree that varies from person to person, a change in "mindset". Notions of this change as a significant part of the transition experience are visible in both academic analysis and literature. Interestingly, there has been a far greater

preoccupation with shedding the old mindset – the "Soviet mentality", rather than a delineation of what new approaches should be. The social analyst Yegenii Gontmakher, highlights four elements of what he says has come to be known as *homo soveticus*,

- A belief that all social problems must be decided by the state (particularly common amongst the older)
- Being accustomed to social equalisation
- A strongly developed sense of "social justice/fairness", understood as equality in living standards and also great potential for "black envy" to the richer and more lucky ones close by.
- The replacement of authentic forms of self-organisation by a pseudo-collective way of life, in which large roles are played by the party, the union, the housing committee.

(Gontmakher 2001: 7)

Alternatively phrased, those who talk of the "Soviet mentality" seemed to be referring to a certain infantilism, an attachment to statist collectivism and possibly dictatorship too, as well as a straightforward levelling-down egalitarianism – all of which may obstruct the development of pluralist economic relations and devolved decision-making. This is especially the case where institutional reformation is mediated through the behavioural conventions of those within. Some respondents who supported the reform process talked about their opponents having a "Soviet mentality" – including one opponent of the new insurance system who used it about himself. Of course, it should be recognised that references to this Soviet mentality are not only dealing with a perceived phenomenon, but also partly rhetorical devices used to abuse opponents who are unhappy with the "new freedoms". As the leading novelist Viktor Pelevin expressed it in *Generation 'P'*

> ...taking the place [of Soviet rule] was only a certain grey horridness, in which the spirit of the Soviet type quickly rotted away completely and collapsed within itself. Newspapers assured that the whole world had been in this certain horridness living for a long time, which was why there were so many things and so much money there, and that the only obstacle to understanding this was "Soviet mentality". What "Soviet Mentality"...was, Tatarskii didn't fully understand, although he used this phrase often and with pleasure.
>
> (Pelevin, 1999: 32-33.)

Thus as part of transition there is a focus on outlook, and on values as part of the adjustment process. Respondents in this study demonstrated a preoccupation (often a frustration) with supposed Soviet psychological legacies – in particular, passive attitudes to health in the population, and incomprehension of the rights and responsibilities involved in the new economics of health on the part of actors in the health care system.

There is of course a tendency in any debate for issues to collapse around opposing general positions such as "conservative" and "reformist", apparently creating a single global choice between two generalised ways of doing things. However, in Russia widely held intellectual habits determined both by the Soviet experience and before, contribute further to the notion of two opposing *weltanschauungen.* The Soviet experience contributes to a focus on mentality as an ineffable problematic. Under Soviet-Marxist reasoning consciousness was produced by material circumstances. As the Soviet Union achieved, according to propaganda, ideal material conditions for the development of scientifically true consciousness, there should have been no dissidence or dissatisfaction. Therefore opponents of the system displayed a mentality that had to be the symptom either of material treachery or psychological illness[7]. It should be remembered that regardless of the theory, the notion of the proper Soviet citizen was an image used to mobilise the population both in production (*e.g.* Stakhanovism), intellectual debate (as employed to infamously devastating effect by Lysenko in agricultural science) and in war. Paradoxically, for a society based on dialectical materialism, there was a strong preoccupation with the innate virulence of ideas.

Moreover, from there has been a debate on the "Russian idea" (for which one might read "Russian worldview") that has occupied many Russian philosophers from the nineteenth century onwards, prompted partly by historical geography (the increasing but still limited interaction between the post-enlightenment West and the post-Mongol East) and the reinforcement of spiritual uniqueness provided by the distinctly national Orthodox church. We may note in particular discussion of Russian maximalism (whereby the extreme and abstract of an idea is explored in its totality), as opposed to Western Rationalism. The philosopher Nikolai Berdyaev expressed (rather than explained) the idea thus:

> In the West is conciseness; everything is bounded, formulated, arranged in categories, everything (both the structure of the land and the structure of the spirit) is favourable to the organisation and development of civilisation. It might be said that the Russian people fell victim to the immensity of its territory. (1937: 3)[8]

In his study of the revolution, Orlando Figes also considers the effect of totalitarian tsarist rule on the tendency of the intelligentsia to "divide up the world into the forces of 'progress' and 'reaction'...leaving no room for doubters in between." (1996: 127), while Isaiah Berlin has noted the tendency of ideas that come into Russia to be abstracted rapidly (1978). That is, in Russia there has been a long-standing intellectual tendency to the global and the maximal at the expense of conciseness and nuance. Of course, as Job (2001) points out, we

[7] In the 1970s dissidents were regularly locked up in psychiatric hospitals.
[8] Of course, I do not wish here to agree with this geographical interpretation of political culture, nor the deliberately implied concern about the "civility" of Russia.

should not fall victim to accounts of Russian exceptionalism, seeking to pathologise problems as somehow innate to the Russian condition – and certainly this thesis is as critical as he is about the neo-liberal reforms, whose failure, he argues, such talk of exceptionalism serves to conceal. Indeed, I argue below that the neo-liberal discourse compounds this tendency to talk in mentalities and outlooks. Moreover, these tendencies can be explained with reference to historical experiences rather than any innate quality of being Russian. Nonetheless, although one must tread carefully around notions of the nature of the Russian psyche (as if there were only one true one), it is also important ethically and methodologically not to dismiss the way that the Russians talk about themselves – and to consider that they *may* have a point, albeit one that is slippery and ill-defined, as Pelevin's anti-hero suggests. One may wish to treat accounts of a bipolar discourse as merely the labelling of opponents as "prejudiced" (such as the "prejudice" against paying for medical services). However, it is important to remember that the apparent slipperiness of such discussions partly derives from a tendency in Anglo-Saxon political analysis to focus largely upon structures, bundling up discourse in amorphous black box notions of "political culture" that are best left alone. One does not need to limit this only to the Russians (pan-Slavophiles would not), nor to attribute it as a genetic fact of Russian-ness across the whole population, to say that there is a noticeably greater tendency than in Anglo-Saxon countries in social and political discourse to speak globally and abstractly about specific issues – and that this impacts upon the direction and form of the debate.

Appreciating this tendency helps to explain the series of comments from respondents akin to that concisely expressed by the head of Vasiliostrovksii *raion* health care in St. Petersburg: "A distributive system cannot work within a market economy". Of course, this is contradicted by many systems of public and social goods provision in capitalist societies, including the UK and Swedish National Health Services before the 1990s. However this incompatibility is expressed not so much in technical terms, but in terms of sense and nonsense – and inevitability. Broad changes *must* be generalised throughout the social system. This may reflect a rationalisation of a certain feeling of passivity in the face of events (not only are medical workers themselves are poorly mobilised as a profession (see chapter 7), the extent and pace of social change more broadly patently can quite understandably bewilder). One needs also to remember that, being in charge of the health needs as well as the health care system of the local area, the totality of the economic and social changes in the past ten to fifteen years (and most were involved as health care managers by the time of *perestroika*) impacts greatly upon both the problems health care workers face and the resources they command. However it also tends to leave the significant

details of health care reform – such as payment methods (such as per treatment or per illness; hospital or patient reimbursement through insurance *etc.*), and the delineation of the purchaser of health (fund-holding primary carers, state fund commissioners, insurance companies or patients themselves), – to be resolved in a rather more piecemeal manner. Given that the precise form of market relations can dramatically affect the cost, integrity, coverage and legitimacy of a health care system (see next chapter), this broad transition discourse has undoubtedly contributed to the complex detailed picture of implementation across Russia, and to the variable success in implementation.

Paradoxically, the same tendency to globalise change produces the adoption of contrary (although not contradictory) principles, as their detailed conflicts are not resolved at the ideological level – the lack of "structure" to which Berdyaev refers. For example, when respondents were asked about access and equity, they almost universally seemed happy to assert the right to equal access to treatment unprejudiced by money and time, as well as the right to buy more sophisticated and effective treatment – without any feeling of contradiction. It is important to remember that this lack of resolution is perhaps more troubling for us than for them. Concern sometimes expressed by commentators over the "Russian" understanding of concepts involved in reform is a little patronising if not colonial. To a certain extent it can also be seen as hypocritical: to globalise change and to pursue contrary principles within that global framework can also be found in the rhetoric of liberal reform.

As with many ideologies, in neo-liberal rhetoric the balance between the global and ideological, and the specific and technical is commonly manipulated in aid of propaganda and argument. Just as pro-reform respondents sometimes dismissed practical objections to change as originating in a wrong, "Soviet" perspective or mentality, ideological insistence on change is commonly predicated on the practical impossibility of any other solution. Those taking part in the debate on both sides have a tactical incentive to globalise the technical differences as a tool of mobilisation and rhetoric – which most often has already beguiled the speaker. For example, free-marketeers argue that human nature requires that any system of production and distribution without material incentives for participants not only leads to exploitation and dehumanisation, it also will simply not achieve technical efficiency: therefore markets are not just morally but also technically superior. Therefore (it is argued) it is technically better that electricity, for example, is provided by a private company than by the state. Ranged on either side of the transition debate are different views of morality and the human personality (often postulated as straw men), involving ideas of incentive, duty and desert, and the relative merits of collective and individual welfare. By then reducing

arguments over distribution and organisation of resources to apparently technical questions, especially when one enjoys the support of governments, corporations and international organisations in making a particular discourse dominant, is to use both smoke and mirrors to cover one's assumptions, and the threat of political isolation for those whose opposition must then become global in order to achieve articulation. When even the kind of Scandinavian social democracy that Gorbachev was tending towards in his final year in power is in profound conflict with the reformist ideas of those advising Yel'tsin, such as Yegor Gaidar, Anatolii Chubais and others as well as of the aid agencies lending or withholding large sums of money, these habits of discourse were inevitable.

In essence, the transition discourse encourages holosystemic change – both through the dynamics of (especially Russian) political debate and discourse, and through the activities of those free-market evangelists in Russia and the West. This has a broad impact upon policy making in the health sector: bringing into question the right of citizens to free health care (despite constitutional guarantees), placing an emphasis on de-Sovietising attitudes towards one's own health (through removing alleged dependency on free health care), questioning the manner in which health care professionals organise (political campaigning versus professional association), breaking down prejudices against profiteering from welfare services through insurance and privatisation and provision (exploitation of the sick versus meeting a demand) and so on. In effect, it has the effect of contesting both the methods and the aim of the health care system in the spirit of anti-collectivism without providing useful principles of access or organisation. In part this comes from a strong reading of markets on the part of reformers as a form of organic "grown" order that benefits from little or no explicit structuring from above (cf. Hayek 1973)[9]. The manifestation of this approach is the exceedingly vague (seven pages long) and at points profoundly contradictory federal law on health insurance that is the focus of this thesis. Moreover, the transition discourse reinforces the sense of inevitability and occasional passivity that respondents expressed at the changes.

Of course, the transition experience has not simply impacted upon the social policy debate. The combined experience of the Soviet system and the subsequent broad reformist strategy has strong implications for the social and material resources available for social policy in practice. It is to the more detailed ideological and practical nature of the transition that I turn next.

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[9] It is worth remembering not only were many of the liberal reformers in the Russian government "reading Hayek by gaslight" in the years before they acceded to power (Lloyd 1998: 215), lack of attention to institution building was one of the criticisms aimed at the World Bank by Joseph Stiglitz,

Transition and the problem of description

Although transition is experienced partly as a discourse of change and conservatism, it is of course mainly a change in institutions and concrete forms of social organisation. Above all, "transition" has been a collection of processes managed and sponsored by governments and international agencies. Although broadly speaking we talk about the move from communism to capitalism, this smoothes over the mixture of the political, economic and social changes that have been taking place. As managed processes those involved of necessity must describe these processes to themselves and others. The problem of description arises from the intellectual tension between dealing with ideal-type models of society and dealing with the societies themselves. In particular the strong policy emphasis on economic reforms has reinforced this process of abstraction, ignoring institutional and social issues both by omission and by assumption.

There are a number of points of analysis for those considering transition. Within academic analysis the focus is often determined by discipline. Political scientists look at issues of democratic change, economists at the liberalisation of economic activity, geographers at changes in human and productive organisation, defence analysts the new military strategic alliances. However, the separation of these trends in analysis tends to obscure points where the transition processes run counter to one another, and where they are in tandem. For example, some argue that capitalist accumulation and democracy go hand in hand, others (including, for example arch-capitalist George Soros, 1998) that they may, and sometimes do run counter. Furthermore, as Stark (1992) argues, the transition field has in practice largely been divvied up between economists and political scientists; this reflects not only the dominant aspects of Soviet social studies, but also the central concerns of domestic politicians and reform supporters. As a result less attention has been paid to more informal social and economic relations that existed alongside and in support of the state-socialist economy and polity. The inter-disciplinary nature of social policy, to which processes of decision-making, economic policy and resource availability are central, is one area where this knitting back together of different processes is especially important. In particular, the dynamics of social policy transformation have at least in Russia pulled not only towards greater liberalisation (through privatisation, greater use of fees and charges) but also to attempts to stabilise through social insurance mechanisms what was previously a residually funded sector and indeed to create new welfare institutions to operate in the absence of social

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the Bank's chief economist who eventually resigned because of his antipathy to World Bank and IMF policy.

control/protection through the state enterprise and full employment. This makes simple binary more welfare state – less welfare state notions of transition problematic, and indeed may explain the inertia in social policy development across the former communist bloc referred to previously as different tendencies with opinions on welfare – liberal, social democratic, socialist – struggle independently to articulate a coherent welfare reform programme that is comprehensive, coherent and enjoys popular or political support. In Russian health care, as examined in chapter 5, there has been a great deal of tension between the liberal economic ministries and the social-democratic welfare ministries.

That the concept of transition itself is potentially normative – implying that there is a fairly clear and usually desirable destination qualitatively distinct from the previous system[10] – has often led to a conflation between description and prescription – between what the end is, and what the end should be according to theory or to that end's desirability. This phenomenon is marked in particular in discussions of democracy and capitalism. At times this tension, it seems is often produced by the emotional, intellectual, ideological (and sometimes financial) investment people and institutions have placed in the transition process. Probably most notoriously in economics the IMF advisor Anders Åslund, in seeking to defend the IMF backed liberal Russian economic programme, has claimed that there has been almost no collapse in output since 1991 (Åslund 2001)[11].

In political science this has led to two related debates. Firstly there are arguments between those focussed more upon the concrete details of a country or region – commonly called (and sometimes derogatorily so) "Area Studies" specialists, and comparativists seeking to develop theories more or less applicable to several countries[12]. The discussion can generate into veiled insults between the "overgeneralising/ignorant" on one side and the "backwater/precious" on the other. Essentially it is a conflict over the value and validity of making comparisons between rather different countries seeking to achieve a better society in a putatively similar way.

Secondly the attempt to describe transition in terms of any putatively successful moves to a market economy or to democracy reveals tensions in theories and concepts. This

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[10] Compare "transition from A to B" with "collapse of A", "degeneration from A to B" and "development of A into B".

[11] His argument is based upon the essential meaninglessness of prices in terms of cost and demand within the Soviet system, the tendency to over-report production levels to line managers, and the production of poor quality goods that robbed raw materials of value rather than added to them (and so in some circumstances the closure of a factory might be seen as a form of economic growth!). Thus he argues that figures indicating severe GDP shrinkage in the first seven years of Post-Soviet rule are largely an artefact (Åslund, 2001).

[12] A classic argument here is the one between so-called "transitologists/consolidologists" Schmitter with Karl (1994, Karl and Schmitter 1995) and east European comparativist Bunce (1995a, 1995b) on the comparability of democratising processes in Latin America, Southern Europe and Eastern Europe.

is partly generated by the complexity of the changes and aspirations in Eastern Europe, where, as Holmes points out,

> None of these countries [the transition countries of Southern Europe and Latin America] has attempted a *simultaneous* and very rapid transition *from* a centralised and state-run and largely nationalised economy, a highly centralised and relatively closed polity, a society largely devoid of a bourgeoisie, and from long-standing military and trading blocs, *towards* a marketised and privatised economy *and* pluralist democracy *and* a society with a powerful capitalist class *and* to new military allegiances and trading blocs (1997: 19).

While other regimes may have changed rapidly, as Schmitter (with Karl, 1994) points out, those others have been able to sequence their changes, unlike the total collapse of both economic and political legitimacy as has occurred in the former communist countries. Testing theoretical concepts becomes problematic as social structures change alongside institutional ones. For example, Dawisha's 1997 discussion of research into whether democratisation in the FSU has been achieved oscillates between considering criteria regarding the firm establishment of democracy (elections *etc.*), and those regarding the establishment of pre-conditions for democracy derived from prevalent theories (*e.g.* the presence of civil society institutions). The tension between prescription and description is also see in her explicit rejection, as is the habit of many, of any criteria which would exclude those countries which are already thought of as being democratic, most typically post-war Italy.

Indeed, it is this kind of gut instinct judgement that shows up a common tendency to reify some concepts of analysis. Because of the challenge posed by post-communist societies to the use of economic and political concepts normally employed in a Western context, there has been a tendency to treat what are essentially approximate descriptive or aspirational terms, each applicable to a wide variety of circumstances (democracy, market economy, privatisation), as actual distinct social phenomena. For example, implicit in early transition economics was the notion that what makes various capitalist countries such as Germany, Japan and the US successful was the same property of "capitalism", despite the marked differences in their historical operation. It seems this is a subconscious intellectual move to combat the deficiencies in understanding of *Western* societies, where the role of the institutional, historical and socio-cultural environments there in producing their peculiar political and economic behaviours is still a matter of serious debate. As a result, commentaries and policy-making dealing with the transition process have been marked by abstraction of desirable policy ends from idealised Western settings, and their transformation into social phenomena produced by (normative-descriptive) transition processes. Gelman characterises this habit as reliance on "teleological schemes of political development", which

has marked "almost all works in this field" (1999: 939), whereby the B in the A to B of transition is too clearly asserted for reality to justify. Given that part of this problem is derived from the not entirely secure comprehension of Western societies, I would go even further than Gelman and agree with Kneen (1998) that our *detailed* understanding of the starting point, the "totalitarian" Soviet regime also requires more work. While Kneen is concerned mainly with the development of science and education in the USSR, this argument also applies to social policy, where the use of welfare as industrial policy to preserve the workforce, the provision through the workplace, and the residual nature of other expenditures is known but little analysed, as well as the scope for debate within the area. The general tendency to abstraction is exacerbated by the dominant ideology of those who have had influence over Russian policy in the years after 1991, the international financial institutions and liberalisers within the Russian government – part of the so-called "Washington consensus" – which with its origins in the microeconomic theories of the Chicago school has a particular tendency to abstract discussion, and to assert the "naturalness" of its theses against an Aunt Sally stereotype of previous practices[13]. Again in health care we can see this with the emphasis from the side of international agencies sponsoring transition (notably the World Bank) and from those ideologues sponsoring change through an emphasis on "markets" and a lack of concern for the concrete alternative forms of relationships between institutions that this prescription implies. While the Ministry of Health Care floundered in inertia, discontinuity and corruption over the 1990s the Finance Ministry sought through various abortive plans to promote privatisation of health care units simply to remove obstacles to some kind of market in health (see chapter 5). In place of an analysis of the requirements of the health service (and indeed, in apparent ignorance both of the trouble with markets in health care and also the internal market reforms successfully introduced experimentally under Gorbachev) there were attempts to draw up blueprints for new systems displaying the necessary liberal qualities. In the next chapter I consider in more detail the problems of policy transfer in health, which mirror these issues of a certain poverty of conceptualisation of how Western health systems operate.

[13] John Williamson, who as an employee of the World Bank coined the term Washington Consensus in 1989 seeks to defend the term as a positive assessment on the basic policy agreements among the Bretton Woods institutions (Williamson 2000), and that subsequent market fundamentalism attached to the label is a misunderstanding. He supports the view that the excessive liberalism of World Bank client governments was a result of their misunderstanding the bargaining position of the World Bank and IMF: these institutions asked for more anti-statism than they thought they could get – and promptly got it. However, given that the World Bank Chief Economist resigned because of perceived market fundamentalism, and that unofficial IMF conditionality in Russia at the very least appeared to depend upon the presence of those Russian market fundamentalists in government (notably Anatolii Chubais), I feel such protests do little to undermine the accusation.

Indeed, economics has dominated the transition debate. There are several reasons for this. There are those in the Russian government who, having been under threat from various anti-liberalisation coalitions in 1991 and 1993, the electoral strength of the communist party in various forms throughout the 1990s, and the problems in Chechnya, have not wished to place too great an emphasis on progress in democratic reform and human rights. Indeed, it became commonplace to defend the irregularities in the 1996 Presidential election (including intimidation of independent media and outright abuse of the election broadcast laws, the interference by the IMF and World Bank by making their loans implicitly conditional on a Yel'tsin victory (Lloyd 1997) and so on) as necessary to preserve democracy and the reform process in the long run. In Sakwa's phrase "liberalism takes precedence over democracy" (1996b: 59). This is exacerbated by the chosen Russian political system since 1993 – a presidential system – which, as Sartori argues (1997), will tend to lead to intractable conflict between legislature and executive, unless the presidency can either buy off or ignore the legislature, neither of which is likely to engender a democratic flush of pride among the population. Some may suggest that Russia may not be as 'ready' for democracy as it is for free markets. As point of fact, whatever doubts there may be about the presence of "democratic values" in the Russian population, or the suitability of democracy for a country like Russia, it is a mistake to think such fears are merely those of idly frustrated outsiders – it is one that has long troubled Russian political debate as well[14]. The corrupt and sometimes brutal nature of Russian democracy in the regions merely fuels this debate. On the other hand, the sponsors of the economic transition have no such agnosticism about the permanency of *homo economicus*. It is therefore much easier to move forward with confidence on economic reform. Most significant of all in pushing the economic agenda, however has been the presence of the Bretton Woods institutions of the International Monetary Fund and the World Bank, whose substantial aid packages have been made conditional on detailed reform to the economic and social sectors. The latter has been determined in great measure by the needs of the former.

The predominance of economics in the transition is ironic insofar as the collapse of Soviet power was arguably first and foremost a political crisis. Manning (1993) argues that the economic problems of the Soviet Union were not of themselves enough to prompt the kind of systemic change that occurred. Citing Habermas' three sector model of legitimation, he points out that similar economic problems in the West since the 1970s have not caused changes on such a large scale, and that problems of social decay and popular legitimacy of the regime were major contributory factors. This thesis is supported by polling evidence a

[14] I do not wish to take part in this debate, but merely call attention to its existence.

few years after the collapse of the regimes across Eastern Europe suggesting that dissatisfaction with the communist system was not dissatisfaction with communist economic values *per se*, but with the regimes in power in the region (Mason 1995). The appeal of market reforms appears to be their legitimacy (people wanted "markets" rather than markets) rather than their desirability to the population. This is not to argue that the populations of Eastern Europe did not wish to transform their countries into market economies, but that the market imperative so visible to economists played a mediating or focussing role in what was essentially a political crisis.

The irony of supposed liberals imposing an ideological model of good practice (in the face of a certain amount of democratic opposition) upon a country that has just rejected authoritarianism has not been lost on some involved in the process. Ellman (1997) raises the Popperian fear of social engineering, whereby the fundamentally erroneous grand socio-economic designs of the communists are simply replicated by those of the capitalists. However, Ellman himself believes these fears are largely unfounded: there are two types of grand social engineering, 'utopian' and 'imitative', the current reforms presumably, being imitative.

> Utopian holistic social engineering attempts to reconstruct society according to a blueprint which exists in the minds of the movement doing the engineering, but which has never existed in any actual society and may be unfeasible. Popper's critique remains valid in this case. Imitative social engineering, on the other hand, attempts to reconstruct society by taking more or less *in toto* the institutions and policies of a system which actually exists somewhere else and is successful there. Although some aspects of Popper's critique are also valid in this latter case, experience in the transformation has shown that under certain conditions this type of social engineering is feasible (1997: 26).

However, he goes on to elaborate neither the particular country or countries from which the institutions are being taken nor which conditions make such wholesale importing 'feasible'. In any case, importing "*in toto*" is an absurdism: we cannot import the population of those countries. Therefore not only can we not import whatever cultural beliefs we may want to shoe-horn into "political culture", we also cannot import the incentives, social knowledge and habits created by one sort of socio-economic and demographic structure into another population of a different by definition "less successful" one. Indeed, it is not clear at what point an institution stops and its client group (who may also be involved in provision, or at least co-habiting with those who are) starts[15]. Therefore any importation of a set of institutions is unavoidably the import of an idealisation, cleaned up of its faults from its host country. It is important to note also the disingenuous phrase "the institutions and policies of a system which actually exists somewhere else and is successful there". Transition economic

policy has not been about running policies in line with the needs of these institutions. It has been an attempt to create them. It is worthwhile reminding ourselves again that in Eastern Europe, and especially Russia, everything was supposed to be changing *at once*. While other countries had some private sector activities and institutions, the countries of the Eastern Bloc had almost nothing of the sort. There is a difference between running and encouraging a thriving private sector and at the same time not threatening a stable ("consolidated" in the literature) democracy with both supervening and interacting with other social forces, and attempting to create them *ab ovo*. The contrast in social knowledge that is required between the former and the latter is immense. There is a big difference between giving giant pandas bamboo shoots, and getting them in the mood to breed. Ellman is also misleading in asserting that the IMF and World Bank were not indulging in Utopian ideals. As Glaser (1993) points out, monetarist policies are theoretical rather than empirical in foundation. When they were introduced in the UK in 1980 (strict control of the money supply and expenditure, with the control of inflation the predominant condition for economic growth at the expense of other tools), they were abandoned after four years. The theories lived on in the rich countries of the G7 (presumably whom we should be copying) mainly in academic textbooks and the speeches of opposition right-wing politicians; the political cost of imposing severe expenditure cuts in recession and using unemployment to limit wage inflation was simply too high. In essence, as Guy Standing has pointed out, there has been a form of "socio-economic experimentation" (1996) in the former communist countries, with a dramatic effect upon the health and welfare of the populations involved. Welfare in particular has been the most abstracted part of this experiment, and I shall argue below, the political and social institutions that have mediated welfare reform in other countries have been undermined, creating a curious *carte blanche* for welfare reform in the FSU.

The impact of economic transition

According to the writings of economists working for the IMF (responsible for broad macroeconomic changes) and the World Bank (specific project investment) in the pages of the *Journal of Comparative Economics* throughout the 1990s, economic transformation from a command economy to a market economy normally should have three elements: price and exchange liberalisation, strong fiscal tightening, and organisational restructuring – commonly privatisation. Price liberalisation entails the removal of price and exchange rate-fixing controls, and the withdrawal of consumer price subsidies. These measures are

[15] For a full discussion of the need to look at social policy from a citizens, rather than a state-institutional basis, see Chamberlayne *et al* (1999).

necessary to permit the operation of the price mechanism – whereby differences in price can reflect differences in both cost and demand for any good – signalling which forms of production are more efficient and which goods should be produced. A common criticism of Soviet-style economic regimes was that they were prone to over- or under-production of goods according to consumer demand. Such mismatches were caused both by inappropriate production decisions with regard to consumer tastes, and also by subsidising – especially essential goods such as food – thereby inflating demand. Freeing prices would eliminate these problems. However, price liberalisation is initially likely to lead to inflation for reasons easily predictable. Firstly, the prices of many essential goods will have typically been suppressed at the point of sale by subsidies, with some having not changed for years or even decades. Secondly, as the adjustment in prices is inevitably unpredictable (if we knew what prices should be, we would not need to liberalise), producers are likely to raise prices because of uncertainty regarding future costs. Thirdly, the underproduction of goods endemic to soviet economies will create 'demand-pull' inflation, as too many roubles chase too few goods, while overproduction is unlikely to result in lower prices. For all these reasons, price-liberalisation is usually accompanied by strong fiscal controls – upon the money supply and upon government expenditure. Producers within a command economy typically make discussions on what to produce and how much according to a plan handed down either from ministries or from local government. In order to be able to respond to price signals, and if need be alter methods of production (including proportionately lowering labour inputs) producers need themselves to be restructured. They need to have the correct incentives to respond to profit opportunities. It is argued that the best way to achieve this is through privatisation.

The end goals of restructuring are therefore free prices, low and stable inflation, and a thriving commercial sector. However, the methods of attaining them are more disputable. The IMF, the chief sponsors of reform in Eastern Europe, and especially of Polish and Russian restructuring, has favoured 'shock therapy' (or alternatively the 'big bang') – to push through all three measures mentioned above at once and quickly. The argument is that they must be done simultaneously, otherwise none of the measures will be effective. Without price liberalisation, private companies would restructure themselves within the wrong price environment. Without restructuring and privatisation, price liberalisation would not achieve its aim, as producers would not adapt and invest in new areas. In both instances, it is argued that more graduated approaches would produce a deformed transition.

As John Peabody has argued (1996), such structural adjustment programmes can have a direct impact upon the health and welfare of the population. First of all, price liberalisation inevitably creates inflation, thereby cutting the real wages of the population. Moreover, those who are paid by the state – teachers and medical personnel – are likely to

have their wages indexed to inflation only partially, as part of the fiscal stabilisation process is cutting back on wage inflation. Employees on the state payroll and on the minimum wage, over which the government has direct control, are most directly the objects of this policy. Pensions, attached to the minimum wage are also kept low. The indexation of earnings-related benefits also provides a headache in hyperinflationary conditions. According to a Social Protection ministry report, coefficients for updating earnings for pensions had been far too low in 1992 (and had been the subject of constitutional court challenges); many pensioners subsequently received the minimum pension only, despite having career trajectories that should have guaranteed the maximum (Izvestiya 1992b). For those working in the health and educational sector such limitations on wage growth are particularly significant given that their wages had been historically low in Soviet terms. Furthermore, tight fiscal policies, inflation and no doubt a certain amount of corruption have resulted in payment of salaries to budget workers in some regions being delayed by anything up to a year. In a system where small "gifts" have been a part of getting better service for years, the increase in out-and-out bribes is inevitable, purely so that doctors could put food on the table. One correspondent for Meditsinskaya Gazeta described many doctors in the late 1990s as operating an informal means test, judging patients by their appearance as to how much to ask them for[16]. The persistence of bribes serves to undermine attempts to regulate payments for medical services, as doctors have little incentive to co-operate if they inevitably see less of any money that is paid to the institution and also taxed, rather than to themselves under the counter. Inflation also undermines state spending and planning; "Social programmes that have already been adopted are frozen and waiting for inflation to 'gobble them up' entirely" complained one newspaper columnist (*Nezavisimaya Gazeta* 1992).

Fiscal stabilisation, as noted above, requires that government spending does not rise wholly with inflation, so as not to fuel it. Therefore real-terms state spending on infrastructure and welfare services falls. Given the residual position that the civilian health service had occupied as part of the non-productive sector of the Soviet economy, with annual expenditure being around a third less as a proportion of GDP than the most frugal of Western countries at the best of times, this squeeze only reinforced under-investment (the level of capital decay in the Soviet Health system is considered in the next chapter). This was at a time when one of the imperatives was to catch up with now more readily available Western technology. Tax receipts in a system where proper taxation on independent enterprises did not exist previously, naturally fell, exacerbating the inability of the state to fund projects. The general shortfall in the planned central budgets resulted in the mid 1990s in the practice of issuing treasury bills [*vekselya*] to the regions. This in turn led to regional systems of debt exchange and the "de-monetisation" of many regions (Lavrov 1998). Within the new health

[16] Private conversation, Russia, 1998.

insurance system, this led to such promissory notes occupying more than half of the turnover passing through the hands of some regional territorial insurance funds (see interview material, chapter 5). More broadly, the lack of funding for infrastructure has serious health implications. For example, in 1993 typhoid and coliform outbreaks in Rostov Oblast' were put down to unrepaired aqueducts and inadequate disinfection procedures (Izvestiya 1993b). In general only 30% of drinking water by 1994 was not hazardous to health, with 145 out of 185 water investment programmes unfunded (Rossiiskie Vesti 1994). As Peabody notes in his survey of World Bank clients "cutbacks in government expenditures can devastate health programs that are solely based on public resources and have an impact on health outcomes" (1996: 831). In the post-Soviet system, with little or no health care market infrastructure, there is no other show in town but the state to provide for health care. When spending falls, it will suffer.

Privatisation, designed to lead to more efficient production choices within enterprises, would have an obvious and immediate impact upon the welfare of a population accustomed to practically full employment. Unemployment services in the Former Soviet Union are historically undeveloped, given that not working under communism was illegal according to the parasitism laws. Indeed, because of this, unemployment centres were initially stigmatised as places for the unemployable, *i.e.* misfits, alcoholics and dissidents. Beyond these cultural factors there were more profound structural problems. Companies had incentives for putting workers on unpaid leave rather than making them redundant – they escaped severance payment, and by lowering the wages paid but not the number of workers, they could lower the average wage and thus lower wage fund taxes (including various social insurance contributions such as health taxes) (Standing, 1994). Apart from that, unemployment registration is a bureaucratic process, and offices have only gradually been built up from a very low level. Most job search and recruitment is not done through employment centres either. Even ten years after the transition, the estimated difference between official unemployment and real (ILO standardised) unemployment is about a factor of five (Ekho Moskvy 2001). A suppressed unemployment rate creates difficulties for the operation of social insurance schemes. The money therefore being paid in through contributions is not linked to the people supposedly being covered (the wage fund is taxed in total, rather than money deducted from each salary. Individualised accounts even for history-based insurance such as pensions are yet to be introduced, although legislated for in 1996.) It suggests that for the health insurance system, even meeting planned collection rates would be in fact insufficient, as those plans are based upon incorrect figures. Furthermore there are those who will not get access to benefits because their employer is not paying for them, and nor are they registered as the responsibility of the state – unless the state underwrites the system, infringing the principle of insurance.

These are the effects of the individual steps in the so-called "shock therapy" approach, where the conversion to a market economy is undergone as soon as possible. Thus in Russia in the 1990s there has been suppressed and growing unemployment, with figures on the jobless being distorted by structural incentives towards non-registration; real wages in the state professional sector (where they were low under the Soviets) have fallen disproportionately, just as prices have risen. By 2001 wages overall had fallen to half their 1991 purchasing level, with many social goods such as housing and increasingly education having experienced dramatic inflation from a very low base (Moskovskie Novosti, 2001) – in addition to informal payments. Resources for welfare have been limited by fiscal tightening, poor tax collection and the use of promissory notes and barter in some regions. Similarly, the official subsistence minimum is kept at the level necessary for physiological survival, without regard for clothing or other living costs.

Aside from the purely economic and commercial problems of this shock therapy approach, the social dislocation caused by the transition has been dramatic. "Health status indicators in Russia are grim and getting worse" (Tulchinsky and Varavikova 1996: 319). It has been asserted that such a catastrophic collapse in a population's health and life expectancy has only been experienced previously in times of war. Most health indicators, static or marginally declining since around 1970 following previous dramatic success at raising life expectancy and lowering infant mortality, deteriorated markedly over the period of 1990 to 1994. The subsequent stabilisation between 1994 and 1998 has been put down to the lowering of alcohol-related poisonings (Shkol'nikov, Mckee and Leon, 2001). In particular, stress-related diseases such as cardiovascular problems and hypertension have increased (Stegmayr *et al.*2000), as well as suicide. Social diseases such as tuberculosis are reaching epidemic proportions, with the overstretched penal system providing a breeding ground for its spread across the country (Electric Telegraph, 2001). Risky behaviours have also increased. The well-documented increase in alcohol consumption has caused particular harm because of the Russian habit of binge drinking worsening potential cardiovascular damage (Britton, A. McKee, M., 2000). Narcotic use has also risen dramatically. There has been a dramatic increase in sexually transmitted diseases. In addition to AIDS reaching near epidemic proportions in some big cities, syphilis has risen by 77 times since 1990, with a 50-fold increase among girls aged 10-14 years (Washington Post 1999), gonorrhoea rising 50% in 1993 alone (Rossiiskie Vesti 1994). Diseases related to poor nutrition, such as breast and prostate cancer, are still increasing. The death rate amongst those between 15 and 29 is 80% higher than in 1991 (Shkol'nikov *et al*). There is evidence of widespread hunger, impacting particularly upon women (Welch *et al*, 1998), which may partly explain the current poor health of Russian infants. Some 75% of all pregnant women in recent years have had a

serious pathology, most commonly related to poor nutrition or a sexually transmitted disease (Washington Post, 1999).

The extent to which this is linked with the transition might be disputed. Although a UN report on the state of Russian health in 1999 stated that "the transition to a market economy has been accompanied by a demographic collapse and a rise in self-destructive behaviour", (Times, 1999), it is worthwhile remembering that Russian health prior to transition had been improved temporarily as a result of the strong alcohol campaign of 1985-86, so that subsequent deterioration does look artificially dramatic. Many health problems, such as those in pregnancy were present under communism, and started to worsen in 1990 and 1991, as the Soviet Union collapsed (Pravda, 1993) The spread of diseases such as AIDS could also be linked to the dramatically increased international flows of people to the bigger cities, coupled with a lack of social knowledge about HIV-prevention which even in a supposedly cosmopolitan city as St. Petersburg is startlingly poor (Amirkhanian, Kelly and Issayev, 2001). Drinking water quality had in fact been declining steadily since the early 1980s (Nezavisimaya Gazeta 1994). Furthermore, one might always wish to dispute health statistics produced by the Soviet authorities.

However, these objections ignore the continuing rapid increase in poor health and social-environmental diseases of over the period of better data collection, the extreme exacerbation of *Perestroika*-era tendencies to administrative weakening, and the obvious increase in drunkenness and social decay visible to any visitor to Russia over the past 15 years. Whatever was bad got worse. This deterioration is also confirmed by respondents in interviews. In particular, the social fallout of the collapse of the Soviet system puts new kinds of pressures on the health system. According to the head of health care in Admiralteiskii *raion* in the centre of St. Petersburg (which, as she pointed out, encounters all the problems the city has to offer), excess bed capacity is being taken up by the homeless, with some wards turning into "hospices". The increase in prostitution, drug use and alcoholism (behaviour which was outlawed and suppressed under Soviet rule) has also put pressure upon the health system. TB, according to her, was allowed to re-emerge so strongly because of the collapse of social programmes under the Soviet regime that had effectively eradicated it. "Amidst all the tension in society we kind of forgot about tuberculosis". Poor housing stock from the Soviet era (that has been deprived of investment since the effective privatisation of housing to a population without resources) has also contributed to various "social" diseases. Food and alcohol poisoning can be largely attributed to inadequately prepared infrastructure for regulating traders, and in the weakness of the centre to intervene in the regions (see, for example, Pravda 1992). In sum, the connection between the severe economic and social dislocation, deeper than in the countries of East-Central-Europe, and the demographic and health crisis seems more than supportable.

In short, it was inevitable and partly predictable that Shock Therapy would have a severe impact on the health care sector: it would cut funding to an under-invested sector, undermine public health measures and worsen the health of the population through stress and weaker regulation of general economic activity.

Shock Therapy as ideological rhetoric and its failure as policy

In actual fact, the Russian economy continued to contract for most of the 1990s, and fell victim to two serious crashes in 1992 and 1998. The 1998 crash, precipitated by the inability of the Russian government to service its increasing debt, and which occurred in the month before the fieldwork for this thesis began, threatened to exacerbate the social tensions and problems created by economic re-structuring (Vilenskii and Domina 1999) although the subsequent import substitution (in tandem with higher oil prices) appears to have helped to boost the economy (Reuters 2002).

Attempts to reconstruct ownership of the economy had resulted, through the establishment of a strong presidency that could implement reform in the teeth of parliamentary opposition, in the creation of oligarchic economic structures whose chief aim was to preserve their financial privileges over and above the health of the economy as a whole (Gould-Davies and Woods 1999). The chief economist of the Bank eventually resigned, in protest at his own organisation's activities in fostering this development (Observer 2001). By its own later admission, the IMF and its allies in the Russian government had paid too much attention to liberalisation, and to crude monetarism in particular (Izvestiya 1998), and not enough to the building of economic and legal institutions that underpin economic interactions.

Just as much as one may accuse economists of assuming the essential existence of *homo economicus* as genetically inscribed into human behaviour, the policy-makers in the early phase of transition assumed the existence of *societas economica*, where the institutions and practices that supported the behaviour of capitalist individuals (the use of personal banking, the availability of loans for business *etc.*) would naturally arise once the constraints of state socialism and the planned distribution of goods had been lifted. This did not happen. Instead, initial rapid voucher privatisation led to millions being issued with worthless shares[17]; banks formed in the late Gorbachev era onwards having too many bad debts to enforce hard budget constraints on their clients for fear of there being a run on their assets; in effect, these soft constraints represented subsidies to failing enterprises that were *reinforced*

by shock therapy. The formation of the bond market, encouraged by the IMF to cover budget shortfalls created by the lack of an effective tax collection system, merely contributed to the escalating indebtedness of the government. Indeed, the IMF itself argues that shock therapy never really happened, although the population itself experienced all the negative aspects as if it had (International Monetary Fund 1995). In particular, stress is laid upon the inexorable delay in land reform and the stalled privatisation process However, such protests have to be considered in the light of their refusal to consider the possibility that *attempting to* implement shock therapy in full *in itself* and rapidly generates contradictory tendencies undermining the success of such reforms. Furthermore, such assertions regarding the lack of reform are undermined by subsequent claims for economic success based upon reform implementation. As stated above in the general discussion of transition, some analysts and institutions have their perspectives heavily influenced by the extent to which their approaches could be proved wrong.

To a certain extent, the presumption of *societas economica* continues in a literalist form: according to an IMF progress report in November 2000, one of the successes has been "many of the basic structural underpinnings of market economies have been put in place in most countries, as least in a *de jure* sense" (International Monetary Fund 2000). *De jure* here could be replaced by "on paper". The achievement of healthier *practice* appears to be left to the vagaries of personalities. The IMF document speaks favourably of two writers arguing that we wait for the robber barons to get old and want to legitimise their gains (for the "predators" to become "conservers"). It also looks favourably upon what is elsewhere commonly referred to as the "Pinochet" option, "the emergence of a strong leader willing to take on the vested interests".

Essentially, this is the continuation of supporting abstract economic reforms with emotional and speculative language in the face of opposition not only from the more socially-minded academic disciplines, but from other economists in principle sympathetic to free markets (*e.g.* Gomulka, 1995, Roland 1994, Jackman 1994, as well as, latterly, Stiglitz). The paradox of demanding three-steps of reform, none of which can survive unless the other two are taken first, was often solved by appeal to psychological concepts of disease and pain. For example, Rodlauer (1995) states that

> Differences across countries in the size of imbalances and distortions dictated some differentiation in the speed and strength of reforms: while the most dramatic big-bang approach was necessary in Albania, programs in Poland, Czechoslovakia, Bulgaria and Romania were also conceived as big-bang moves, whereas Hungary was able to go with a

[17] As one university lecturer in Volgograd commented to me once "we still have our certificate. It's very pretty. We might frame it and put it on our wall."

> more gradualist program, although it was still far more comprehensive and front-loaded than anything Hungary has attempted in the past. (98)

That is, the severity of the transformation is directly connected with the perceived severity of the problem. The worse the offender, the shorter and the sharper the shock. A common mode of expression is to consider the problems of transition a 'disease' (Götting 1994: 185); commonly inflation is 'virulent', and Gaidar (1997) entitles an article on the need for financial stabilisation 'Childhood Diseases of Post-Socialism'. The implication is that no matter how bad the medicine, one has to take it. Society and organisations are subject to anthropomorphism. Companies need to undergo "shake-out" rather like drunks. The "endless race between prices and wages", according to the Minister of Labour Aleksandr Shokhin in 1991, should have died out after a year and a half, as "a natural fatigue will set in for the economy and the population" (Rossiiskaya Gazeta 1991). Such emotional reasoning tends to persuade practitioners that poor outcomes result from patients not following doctor's orders – and that anything apart from a successful free market system is deviant to the point of pathological.

The abstracting tendencies of the approach (as discussed above) also raise rather simplistic totems such as marketisation and privatisation, the achievement of which in itself should be counted as a success, rather than as a means to success. This is part of the "world view" change referred to earlier in this chapter; thus privatisation and marketisation are seen as good in and of themselves, rather than privatisation of x in the economic context y because it produces benefit z. As Jackman (1994) points out, we need to remember that the growth of the commercial sector is qualitatively different from privatisation of the state sector; however such subtleties (!) are often too easily glossed over. As discussed in the next chapter, the value of markets to health care, for example, is eminently disputable. Behind the language of imperatives, abstractions and technocracy, there are concealed real choices. And the far reach of the transition process in Russia has naturally infected social policy formation, to which the focus now switches.

The impact of "transition" on social policy formation

Social policy itself can be viewed as having three different functions within the transition process. Firstly, it is seen as a tool of economic policy (Kosmarskii and Maleeva, 1995), where the resources put aside for welfare, in particular pensions, can be used as funds to develop the investment market. Welfare can also be viewed as significant in improving human resources available for capital. Secondly, it is seen as a means of lessening the social tension created by the transition process, of buying peace, a dominant concern of the World

Bank. Thirdly, it is seen as a non-productive cost that can disincentivise the work force, so therefore needs to be kept to a minimum. These three aspects generate grounds for the transition approach to encompass social policy developments.

There are two dominant influences that the transition has had on social policy development. Firstly, the resources and dynamics for social policy formation and provision have been adversely affected by economic transition; secondly, that Friedmanesque ideas for welfare reform have had far greater currency than in most other countries.

As part of the theoretical dynamic there is ignorance of the nature of Soviet welfare - as mentioned above, part of the problem of describing our starting place in transition accurately. Firstly the role of enterprises as administrators of welfare has been underplayed. Legally enforced full employment made the Soviet workplace the strongest contact between the population and the state and thus the most efficient (as well as ideologically more acceptable) source of social provision. Not only were health care units placed in large enterprises, it was through the workplace that the impressive achievements of Soviet medical prophylaxis were made – such as extensive health checks and public education. Holiday facilities and pioneer camp arrangements were also widely available, as well as some access to housing. Commonly many benefits were administered by trade unions, but the interaction between enterprises and unions made this distinction a little academic. To move from this model to a capitalist one where all social benefits are part of a market wage, and where trade unions are more effectively separated from the employer (and have therefore weaker control over enterprise resources), in shortage conditions created by the disruption of transition, has served to deprive many people of benefits they might otherwise have received. Indeed, the main bulwark against this diminution of workplace welfare has been the provision of benefits in lieu of wages that firms are unable to pay. Although the World Bank vice-president responsible for social policy in Eastern Europe noted the problem of the reduction in enterprise based welfare (Izvestiya, 1993b), and suggested an increase in social expenditures by 5%-20%, the Prime Minister Yegor Gaidar had a few months before vehemently argued that fiscal stabilisation was more important in providing social welfare (Rossiiskaya Gazeta 1992).

Furthermore within broad transition theory there is a profound misunderstanding of the extent of Soviet welfare transfers. Shock therapy emphasises fiscal tightening and spending reductions, as if the state had been profligate. However, the main task in Russia is surely *to raise* welfare expenditure to acceptable levels. Being part of the non-productive sector, and employing those with higher education who were not as rhetorically important as the strapping worker with hammer in hand, the wages and resources available to both health

and education in the Soviet era were distinctly residual (Davis, 1993), although universal. Trade unions in this respect too are not smiled upon because of their alleged obstruction to wage restraint (Jackman 1994) and free labour practice, even though effectively they were controlled by management to maintain workforce discipline. Other more substantial measures, such as subsidising food, heating and electricity have also been removed, conceptualised not as welfare but as price distortions. No benefits were increased in compensation, threatening food security of an impoverished population

These two misconceptions combined create a third problem. The liberal economic welfare agenda of "targeting the most vulnerable for help" (*e.g.* Russian Government 1995) not only undermines the universalist Soviet tradition (and so arguably imposing a welfare choice upon a population still attached to more egalitarian ideals), it also demands the creation of new welfare agencies to administrate the condition of the poor – mechanisms of income assessment and outreach – which simply did not exist previously: there was little or no need, or these needs were met through other, often punitive agencies. The growth of the black and grey economies in conditions of weak economic regulation exacerbates the problem. Even in 2001 accurate measurement of income for assessment was nearly impossible because of grey and black economy activities (Moskovskie Novosti, 2001). Thus the ignorance paid to institutional development (or possibly the assumption of its development) that occurred in economic practice also had repercussions in the welfare sector.

Quite simply, the transition theory model of the economy rapidly undermined Soviet methods of welfare provision largely on economic and political theory grounds without providing clear mechanisms for their replacement.

The influence of free-market rhetoric, given a freer hand than possible in Western countries (the reasons for which are given further below), also affected the social policy debate – and arguably led the policy process into stalemate through the extremity and infeasibility of the proposals. Partly this influence results from the subjugation of social policy to economic policy, partly because of conditional recommendations on the part of international financial institutions at the time, and partly because there have been ideas for welfare in the Chicago school that had been looking for a test-bed. In general welfare reforms involve a distaste for state provision; the "empowerment" of citizens to choose how they spend their money over a lifetime (often through individualist private insurance arrangements) as opposed to social insurance; and introducing, sometimes dramatically, elements of consumer choice and producer provision. State provision is fundamentally undesirable because it is inefficient and paternalistic – although this is a point not formally

proven according to Ellman (1997). One should note the historical specificity of the period: Deacon (2001) argues that the 1980s and 1990s was the heyday of these minimalist approaches which is now fading; the collapse of communism and the rise of neo-liberalism undermined the self-confidence of social democrats and gave rise to the "myth of the market", ignoring the European solidaristic experience.

Thus the reformers at times pursued a role for the state in welfare provision that was significantly smaller than in most industrialised countries. Part of this strategy is often referred to as focussing help on protecting the most "vulnerable strata of the population". Originally, framed in terms of crisis management (*e.g.* Izvestiya 1991b), it soon became part of the overall vision for social policy (*e.g.* Russian Government 1995) – so that the state no longer becomes involved in welfare provision for the non-poor. Pluralist proposals in welfare include finance ministry support for the Chilean four-pillar model of pensions (state flat-rate, state income-related, occupational and private pension provision for all in complement) (Sevodnya 1995c), despite its dubious success in its home country and an underdeveloped financial sector in Russia; continual support for vouchers in the educational system (Russian government, 1995, Buzgalin 2001); and attempts wholesale to privatise the health and educational institutions (*Financial Times* 1994; *Kommersant-Daily* 1994). There have even been suggestions to turn social claims on welfare resources into stakes of stocks and equity (Russian Government 1995). Almost all of these sorts of welfare reforms are still merely proposals, because of legislative inertia at the centre, generated both by opposition within the "social ministries" of labour, social protection and health populated by left-wingers), and by the inactivity of some of those opponents in suggesting and doing anything else (Sevodnya 1995b). One must also suspect that, given the radical nature of many of these proposals, that would inevitably run up against the weak administrative state and the absence of stable financial institutions, they were never going to be followed through, being perhaps tactics in intra-governmental conflicts. Implementation difficulties are demonstrated by the problems found in trying to encourage a market for voluntary health insurance in the early 1990s, and the subsequent establishment of compulsory medical insurance. Pluralist solutions have been compromised by the need to strengthen parastatal organisations such as territorial medical insurance funds. The current Putin government has appeared far keener to assert state responsibilities for welfare provision, although not shying away from employing quasi-market solutions (*e.g.* in education see Asia Times 2002), partly as a result of trying to bypass corruption.

This deadlock at the centre of Russian social policy making in the 1990s, evidenced by the lack of significant new developments since the reformist laws of the last year of the

Gorbachev era, is typical of many East European countries, where liberal governing parties have not prioritised social policy reform, despite having a clear anti-state agenda (Ringold, 1999; Götting 1998). As a result, many communist-era structures have remained in these countries, although in East and Central Europe compulsory health insurance has been widely introduced– a result of more direct interest on the part of international institutions, notably the World Bank and the European Union (Deacon and Hulse, 1997, Deacon 2000, Marrée and Groenewegen 1997). What is noticeable is the absence of other organised socio-political forces pushing change in welfare, the discussion of which we move to next.

The formation of social citizenship and problems for Russia

Prompted by T. H. Marshall's analysis of the development of social rights, Turner (1991) defines citizenship thus:

> Citizenship may be defined as that set of practices (juridical, political, economic and cultural) which define a person as a competent member of society, and which as a consequence shapes the flow of resources to persons and social groups (p. 2)

The concept is important in understanding the access to resources common to all people, and reflects the social demands articulated by the population over a historical period of time. Citizenship in this sense is part of the institutional structure of any capitalist society – part of the compromise between capital and labour, and between the rulers and the ruled. Important in the definition is the word 'practice', which also suggests that any particular set of formal rights is accompanied by a set of informal social, cultural and political practices that may function in the same way as rights, but are often not formally expressed. This definition therefore expresses the embeddedness of social structures within the society one is considering. The legacy and then collapse of Soviet power and the subsequent policies pursued by the Russian government in the 1990s have undermined the development of these structures.

Different commentators have posited historical reasons for varying forms of social welfare systems. Esping-Andersen (1990) identifies three sorts of welfare system in the West that are linked with the presence or absence of a strong religious or ideological tradition – resulting in minimalist, hierarchical or universalist characteristics. Lipset's (1983) historical analysis of working class activism attempts to explain the political and labour traditions of European countries through the establishment of economic and political citizenship for the working class. King (1987) also suggests that strong working class movements are necessary to achieve Marshallian social advances. Manning (1993) identifies the extension of social

rights with popular movements of some sort, whether they actively achieve their aims, or, in the Bismarckian case, their presence generates change. In health care in particular, outcomes such as the British NHS or the French mixture of private and public institutions operating within a corporate insurance system are put down to the relative strengths of the state, employers, the labour unions and medical providers.

Common to all these explanations is the existence of conflict between the state and other sources of power, whether that other source of power be the church, trade unions (and social democratic parties) or protest movements. That is, social rights in other Western countries have been generated in a large part, by pressure from outside the state, from organised "civil society". Most commonly there is a *compromise* between these particular forces. This is especially true of health reform, as examined in the next chapter. However, the transition process itself is focussed on state-implemented reforms, ignoring other institutions. As the struggle for citizenship rights is, at base, a *dynamic* one, reflecting the power of various institutions, what institutions exist in Russia that could influence citizenship development?

The church in Russia has rarely stood in powerful opposition to the state. It inherited the two-pillar model of co-existence with the state from the Byzantine Empire, whereby it is responsible only for the spiritual, rather than the material health of the population. Its involvement in welfare even during the period of late industrialisation has always been very small (Madison 1968). Its authority lies over the same ethnic-geographical territory as the state's, as opposed to the universalist characteristic of Protestantism or Catholicism (Lloyd 1998). It therefore has no separate political and moral authority to which it could appeal if it so wished. Devastated in the 1920s and 30s, its current hierarchy is dominated by traditionalists, anti-Semites and former KGB informers, who have explicitly sided with the reformist government, to the extent of Patriarch Alexei III blessing soldiers going into war in Chechnya. It apparently has little to contribute to the debate on welfare, either through provision, or in shaping any particular view of material social justice.

The labour movement is equally weak. Trade unions under communism were part of the 'transmission belt' from the top downwards, part of the total production process. They still commonly include in their ranks managers as well as workers (Sakwa 1996b). Indeed, Lloyd goes as far as to say that trade unions have in the past 'functioned as personnel departments' for enterprise managers (1998:247). Therefore as representatives of the interests of workers the traditional trade unions, reformed, de-étatised and often stripped even of their social functions, are discredited. Attempts to organise at a national level have not been entirely successful, with the role of the traditional trade unions ambiguous in their

electorally unprofitable alignment with the main managerial parties, and the new unions without a great deal of support and largely divided. (The one exception to this case is the miner's union, which has successfully continued to defend the interests of its workers in the face of non-payment crises.). MacAuley (1997) suggests that the new patron-client relationship between employer and employee, characterised by the continued presence of over-employment in factories undermines the formation of new unions. Lloyd talks of 'desperate co-operation' with bosses in the context of a harsher managerial capitalism (1998: 324). It is not surprising then that attempts at German-style tripartite social partnership (for example, see Roik 1993) have generally floundered or become merely formal arrangements, reinforcing the traditional managerial rather than representative role of the unions. From the interviews with the leaders of medical trade unions and newspaper sources, it is clear that the trade union movement itself is merely a voice in debate, and not a very loud one, that questions the rationality of health insurance. In particular, the medical profession has been poorly organised. A longer discussion of the problems of the medical trade union is undertaken in the analysis of the interviews with the trade union heads (Chapter 7).

Charitable organisations and other civic organisations have a distinctly local flavour. Perestroika-era charities made a historical decision not to organise nationally (White, 1997) – a practice that persists today. Manning (1993) suggests that environmental groups provided the first form of political pressure in Eastern Europe in the processes that led to the political transformation. However, these groups were subsumed into larger groups when political collapse arrived; the Russian environmentalist party *Kedr* failed to win any seats in the 1996 federal election, and has since faded from the national scene under allegations of funding from certain polluting industrial concerns. Manning concludes that overall, there has been an absence of pressure politics in Russia.

Thus those social and political institutions that normally mediate developments in national social policy in other countries are absent in the Russian political context. Once the liberal agenda began to lose steam in the mid-1990s, one correspondent wrote "there is virtually no political force that has any sort of intelligible programme for reforms in the social sector" (Sevodnya 1995b). In this light, the social insurance model in Russia around the beginning of the 1990s introduced for pensions, health care, unemployment and illness (laws prepared in the last couple of years of the Soviet Union) are curiosities. Social insurance in the West has been the result of a compromise. The stability and legitimacy of these models is dependent upon conflict and support between counterposing forces. However in Russia they have been imposed as a rational model – if anything a compromise not between social forces, but between the social democratic and marketising ideological

tendencies present in the latter years of the Gorbachev regime. One must therefore question the relative stability of these reforms. Indeed, it is one of the main arguments of this thesis that the stability and durability of the health financing reforms must be in question in some regions, as the institutions created (and governed by representatives of the two sides of capital as well as the medical profession) do not represent the aggregate of social forces at work. Instead they represent an ideological compromise between pluralism and dirigisme. Such a compromise as this has no particular reasons for being maintained; systemic logic in the instance of health insurance may dictate, I shall argue in this thesis, a choice between the two.

Lastly, the hardships and diminution of official access to resources for citizens has strengthened *old* informal networks (Stark, 1993). Access to resources is bound to depend partly on membership of pre-existing groupings, notably one's own family and the *nomenklatura*, given difficulties in obtaining resources in the white economy. Nepotism and corruption are therefore inevitable. Thus unofficial avenues of privilege under the old regime not removed by market imperatives, but are positively strengthened. This process infects the health system in the awarding of contracts to insurance companies, as witnessed in Volgograd (see chapter 8).

The overlooked transition – decentralisation

A neglected but important change in Russia has been the dramatic decentralisation of the political system. The relatively sparse amount of social policy research on Russia has naturally been under pressure to answer the question "what's going on in Russia" as a whole, and to "fit" Russia into international models of social policy. However, decentralisation has had a dramatic effect on social policy, and on the health sector in particular. This change results from three particular aspects – responsibility for welfare, control over property, and financial arrangements between the regions and the centre. In principle, there could be 89 different answers to many social policy questions about Russia.

As a federation, Russia is divided into 89 subjects – 49 oblasts, 21 "ethnic" republics, 6 krais, one Jewish autonomous oblast, 10 autonomous okrugs and two cities. Within these subjects there are cities, towns and villages. Some of the larger cities are subdivided into municipalities, called *raiony*. In terms of social welfare, the constitution gives jurisdiction for general ecological and cultural matters and the protection of human rights. Joint jurisdiction between federal government and the subjects covers in addition to the above (which is also part of joint jurisdiction) "general issues of education, science, culture, physical fitness and sport" (art. 72 (1) (f)), "the co-ordination of general questions of

public health; the protection of the family, mothers, fathers and children; social protection, including social security" (art. 72 (1) (g) and housing (art. 72 (1) (j). These general terms have allowed the state to pursue a policy of decentralisation of welfare policy. Housing is now the matter of cities. Education is predominantly a matter for the federal subjects (with the exception of the curriculum), as is organisation of the health system. Only pensions have remained in principle a matter for Russia-wide policy, and even then some regions, notably Moscow City, subsidise pension increases. There are two purposes behind such moves. Firstly, it is to counter what was seen as excessive centralisation in the Soviet period. Secondly, it is a useful method of cutting central social expenditure. One might argue, as does Mitchneck (1997), that the return of such social functions to the local level represents a return to tsarist practice. However, this is misleading because modern state welfare provision is far more extensive than under the tsars, and because the study producing these conclusions considers only municipalities of cities (primarily St. Petersburg and Ekaterinburg) whose access to resources and independence in action is conditioned by their attachment to large entities with good control over resources. Thus the decentralisation is actually decentralisation of the responsibility for modern universalist state welfare.

The law on local self-government passed in 1991 has given some places in the Russian Federation four tiers of administration, two of which are in practice semi-autonomous from their higher branch. Property pertaining to the subjects and the cities, towns and villages within them cannot be disposed of by a higher level without legislation, and then not outwith the bounds of federal law. In effect, each town and village has a certain degree of independence from the regional authorities, while the subdivisions of any large town are more directly under the control of the town authorities. This has had particular impact upon the health sector, as the interviews bore out. Co-ordination and rationalisation of a system that had suffered from irrationally high levels of hospital capacity has proven difficult; mechanisms other than direct orders have been the only successful method. As a result, Moscow and St. Petersburg have an advantage over other parts of Russia. They dispose of money granted/left them by the centre, and they also have authority over the *raiony* within them, who, as civil municipalities are creatures of the city authorities. That they are also relatively wealthy only reinforces this advantage. By contrast, governance in Volgograd Oblast' was typified by conflict between the region (and many of the smaller towns) and the larger cities, and especially the regional capital.

The decentralisation of much property has implications for the study of central policy: one of the instruments used to push forward the liberal economic agenda – the State Property Committee under leading reformer and IMF 'favourite' Anatoly Chubais – could

only put forward such reforms as the privatisation of educational and health institutions insofar as they related to federal property (Kommersant-Daily 1994); other attempts at privatisation were open to constitutional challenge. Therefore much of what was planned or announced in the central press by the so-called liberal ministries of finance and economics in Moscow regarding social policy reform actually had limited bearing upon what happened in the regions. That various attempts to achieve these aims were frustrated by nationalists and communists in parliament only serves to muddy the waters about what was happening on the ground. In particular, the tactic used by opponents of exacting reasonable promises to put forward more encompassing federal laws before more pervasive action would be taken regarding privatisation (Sevodnya 1994) – thus more or less guaranteeing inaction – can confuse analysis if one believes these laws are actually forthcoming.

Thirdly, decentralisation and the financial autonomy of the regions reflect a dynamic process ongoing since before the collapse of the Soviet Union. Again, attempts to address dysfunction in the Soviet system began under Gorbachev. As part of *perestroika* the government introduced "regional economic accountability", a kind of self-financing within regional areas, which liberal politician Grigorii Yavlinskii identified as the "prototype of today's territorial separatism" (Izvestiya 1991a). As Yergin and Gustafson (1994) point out, Russia has moved from an empire to a federated nation state containing many ethnicities. Such a transformation changes the necessary legitimation activities of the state. There is a greater rhetorical emphasis on public welfare as opposed to national glory, and on agreement between the centre and the regions, rather than governance by diktat. Furthermore, the strategy of Yel'tsin in undermining Gorbachev was to attempt the break up of the Union – encouraging the union republics and areas within them to seek greater autonomy if not outright independence (Sakwa, 1996b). Thus the history of centre-regional relationships in the 1990s is of yo-yoing concession followed by reassertion of central authority, particularly through the symbolism of increased and sometimes voluntaristic[18] military efforts in Chechnya. Of particular notoriety is the "parade of sovereignties" in the mid 1990s when the ethnic republics sought to assert greater autonomy and self-determination. Although constitutionally, all federal subjects enjoy the same rights, separate agreements were concluded with the republics granting them greater autonomy and control over tax revenue and foreign relations. As a result, other regions also sought to gain more concessions from the centre as well, on constitutional grounds. However, developing at the same time was regional resistance to the Yel'tsin government, resulting in the cancellation of regional

[18] Here voluntarism is used with the emphasis on its Russian political meaning: "the taking of subjective arbitrary decisions, ignoring objectively existing conditions and order".

elections from 1993-95 and the imposition of governors in many regions. Subsequent relaxation of control over the regions is now being followed by Putin's reassertion of seven super-regions designed to co-ordinate policy. Thus the centre's regional policy is unsystematic and varies greatly over time. McAuley (1997) has shown that the amount of federal subsidy has little to do with local need and much to do with bargaining strength on the part of each region. In general, the relationship between the centre and the regions has also become more distant. The decentralisation of policy and the weakness of the centre to enforce intransigent subjects to toe the line are coupled with central inaction in many areas, noticeably in health policy (see chapter 5). Many respondents in this study, regardless of their office, actively wanted the centre to give direction. In the case of the administrators and trade unions, a majority felt that the "vertikal'", the direct line of authority from the centre to the locality had to be reintroduced, strengthened.

There are two aspects to decentralisation of interest to policy analysis and assessment. Firstly, that regional variation in implementation and success is likely to be high: the applicability of federal law in any one region depends upon the ability of that region to bypass federal actions, and on the peculiar funding arrangements for that region – including the use of promissory notes from the centre, and on the desire of the centre to devote resources and attention to enforcing federal norms. In health care the wide variety in the models of health financing derived from a single law is testament to this variability. It therefore is important to consider many social policy developments in Russia as fundamentally *regional* processes, without necessary generalisability to the whole country. Research must be done first and foremost at the regional level. While an emphasis on the current fashion for looking at globalisation in social policy is understandable and indeed interesting, it can lead to unhelpful generalisation in a country as large as Russia, glossing over variety within.

Secondly, attempts to "marketise" and "privatise" social policy provision, especially in health and education are by constitutional and legislative necessity segmented into regional systems. In most Russian regions there is often either not the dense population or the economic wealth or profile or quite simply the hard cash to support such experiments. In health care, social insurance designed to allow non-state insurance companies into the welfare system to compete has resulted more importantly in altered forms of public governance rather than outright marketisation. As the private sector insurance companies found it difficult to thrive in these circumstances, independent or arms-length dominant actors, not infrequently municipally or state-owned have become intermediaries in funding and organisation. Additionally, the different levels of government have reduced leverage

over those below them, while those below have limited access and influence over those above. Processes of decentralisation and attempted pluralisation have resulted in negotiated policy processes between dominant actors, most of them public. Relationships are not subject to competition so much as *contest*. In the context of post-Soviet bureaucratic habits and practices and also of financial shortages, this change is different to and in practice far more important than simple issues of marketisation and privatisation, and one, which has had far less attention.

Conclusion

In summary, the relationship between transition and social policy (and the health sector in particular can be summarised thus):

Firstly, in considering the development of social policy, we must remember to consider both the reforms undertaken during the Gorbachev years, and the exact nature of the Soviet legacy. Sectorally, these reforms have had a longer-lasting impact than might have been thought, particularly the social-market reforms in the health sector. The longevity of these reforms is partly due to the failure of more radical reforms.

Secondly, the transition is not simply an alteration in the institutional arrangements for resource distribution and re-distribution, but an ideological experience and an ideological conflict. This creates a tendency both on the part of reformers and the (Russian) subjects of their reform to maximise the characteristics of market reform, and to seek to extend them further into social life. Thus social policy is exposed to (unusual) consideration for radical market-style reform. The absence of the sort of mediating social forces that in classic descriptions of social policy development are key to compromise policy outcomes allows such experimentation to take place with less resistance, but also contributes to the initial arbitrariness of reform models.

Thirdly, the impact of the transition was *bound* to have deleterious consequences for the welfare of the population in the short term, and the subsequent (and by some predicted) relative failure of these reforms to bring forth economic prosperity in the following decade have merely reinforced those consequences in the longer term. Furthermore the social problems created are relatively new (with the exception of alcoholism), and existing institutions, in particular the health system, are being drained of resources that should be directed towards their proper function.

Fourthly, dominant transition processes have neglected and thereby undermined Soviet social policy institutions, while proposing untested theoretical models for welfare provision in their place. As a result there has been inertia in social policy development at the

centre over the first ten years of post-communism. This has been exacerbated by the decentralisation of social welfare to the regions.

Lastly, a significant but under-considered element of the transformation in Russian social policy has been this dramatic and uneven decentralisation of authority for welfare and control over state and municipal property. In conjunction with attempts to introduce competition in welfare (which has advanced most in health care) the most significant effect is to introduce unfamiliar (to post-Soviets) forms of co-operation between levels of government and independent and quasi-independent bodies.

4. The international context of Russian health reforms

The reform of the Russian health care system, and indeed many health systems across Eastern Europe, is the unusually dramatic transformation in their financing since 1990. It is what Wessen (1999) calls a "mature" health system: primary, secondary and tertiary care "acceptably" accessible to all or most of the population[1]. Such systems are rarely reformed so radically – from the funding of care through putting general revenues into a highly centralised administrative system, to a decentralised insurance system based upon a hypothecated wage tax. However, the changes are based within wholesale reforms within society (witnessed by the attempted serious reform of *every single sector* of the welfare state and economy in the early 1990s), with the encouragement and pressure of international financial institutions. Only partly have these specific changes come from internal pressures or an analysis of the extant system, despite the waves of criticism about Soviet health care during *Perestroika.* Indeed, successful experimental regional reforms under Gorbachev that more directly addressed those problems were actually superseded by the insurance reforms, their widespread implementation abandoned.

It is the task of this chapter to put the Russian reforms into context – in terms of the general issues in health care reform, and in the debate on the politics of health care reform. It involves consideration of the general patterns of health provision in the industrialised world, specific consideration of the Soviet system, and an assessment of what Glaser (1993) calls the "vogue" for competition – reforms guided by neo-liberal economic concerns.

Health care systems and their problems

Twaddle (1996) goes into detail about the variety of ways in which health care systems can be compared internationally, according to financing mechanisms, the level of private involvement, the balance between primary and secondary care, health care rights and so on. For current purposes, I shall divide mature health systems into two groups, "social insurance", and "national health systems", excluding from this analysis the United States. Some, such as Semyonov (1996) calls this a divide between, "Bismarckian" and "Beveridgean" systems, but this needs qualification when one considers the national health systems that were common in the old Eastern bloc. The source of this institutional difference can be argued to rest on the particular political and institutional structures and political

[1] One feels slightly that this definition has been stretched a little so that the US system, with almost a fifth of its population notoriously without any medical insurance cover and another fifth with only partial cover, can be included in the analysis.

ideology of countries in question (Indeed, Giaimo and Manow (1997) suggest that in Britain and Germany the financing arrangements are almost expressions of national identity).

Social insurance systems are characterised by the presence of health insurance funds and companies, who cover most if not all the population (there are often exemptions on offer for those who are higher earners, as well as those who fall through the net). There can be many funds (as in Germany, with hundreds of small organisations) or one or only a few, as in Israel, France or in Georgia; these funds may be based upon locality, or profession, or individual or employer choice. Contributions are paid for through work (the balance between employer, employee and state contributions can vary), with the state (typically local authorities) subsidising those not covered. The level of contributions is typically determined with government approval, with some countries allowing for limited variation in contributions between funds. Different contribution rates may exist for different occupational groups. In many schemes dependants of the working are covered by work-place plans. Coverage can vary at the margins according to the policy held, as well as there being variance in the quality of hotel services. Part-payment by patients is common (France is typical), although this payment can be covered by voluntary supplementary insurance. Overall social insurance systems tend to be much more decentralised than national systems. In many social insurance systems expensive procedures and chronic illness are often paid for by the state to help funds with expensive patients (and to remove the incentive to cream-skim healthier patients); in some countries this has led to co-ordination problems between institutions funded on different bases – for example in Germany and Austria (Theurl, 1999).

The national health system model is characterised by state owned and financed healthcare institutions, where what charges patients pay tend to be low and unrelated to the cost of treatment or medicines. Access is universal, equal and comprehensive, at least in theory. Historically, they are administrative systems, although there have been recent reforms in many of them to introduce competitive elements between actors inside the system. Marrée and Groenewegen (1997) draw a distinction Beveridge West European systems and Semashko systems (named after the first Soviet health minister) in Eastern Europe – with the latter featuring primary care polyclinics containing teams of lower-level specialists rather than General Practitioners, greater central control and specific health systems for certain professional groups, as well as a strong emphasis on preventive measures through the workplace. One should not forget their context of highly unresponsive political systems and weak organisation of medical staff and labour that fostered official complacency (Tegai and Azarov 1997). The example of the Soviet health system is discussed in detail below. In the discussion of problems in health services immediately following I shall discuss

a model of a national health system common to Eastern Europe, and the UK and Sweden before their reforms of the late 1980s onwards – that is without a purchaser-provider split.

Systems with incomplete coverage, commonly in developing countries, but also in the United States tend to experience a mixture of private insurance and some state services, as well as larger charitable sectors. In many poor countries, most typically the former European colonies, services are often focussed on servicing the elite and urban areas, with less available in rural areas (Sen and Koisuvalo 1998). Primary care tends to be underdeveloped in favour of hospitals. The United States relies much on occupational insurance, with comprehensive services state funded only for the very poor and the elderly. The incompleteness of US medical cover has become a salient issue at the presidential level for over a decade, including both the Clinton and Bush (jnr) administrations, although solutions have tended to focus on individual insurance (Jost 2001).

The division between these two systems could be seen, as Semyonov, suggests, to be "fading away" (1996: 8), with national health systems experiencing both growth in voluntary insurance and market mechanisms, and the tendency in social insurance systems to move towards centralisation and consolidation of insurance funds, as well as similar tendencies in framing the costs of treating illnesses. However, I feel this would be to underplay the fundamental differences in their structures and governance, and the difference in problems that they experience.

Coverage and Access

The World Health Organisation's Alma-Ata declaration (World Health Organisation, 1978) announced on behalf of its members states the status of health as a social right. It focussed on reducing the inequalities between the health "haves and have-nots", announcing a target of "health for all" by the year 2000. That is, that all people in all member countries should have health care available to them, including the financial support to those who could not buy health care. Problems of coverage and access can result either from the lack of local facilities (which commonly affects rural areas) or inability to pay – commonly resulting from 'holes' in the net of private or social insurance. Mature health systems (by definition) suffer far less from these problems. While national health systems effect 100% coverage, social insurance systems, being founded on the institution of full-time employment, have traditionally had difficulties in insuring agricultural and other seasonal workers, and have often had to develop separate schemes to overcome this problem. The connection between contributions and access means that where employers fail to pay, their workers may be refused treatment. Thus countries with weak institutional discipline can experience gaps in

coverage – for example in many Latin American countries (Fiedler 1996) where the state has failed to honour insurance commitments for its employees. Such problems have led some regions of Russia to introduce health insurance only for those in employment rather than those who would be covered by the local authority. Some argue (*e.g.* Chinitz, Preker and Wasem 1998) that the uneven and institutionally fragmented development of social insurance in some countries has resulted in unequal access to services because of different premiums for different occupation groups (which can often represent different health risks either by social class or by occupational hazard), as well as the right in some countries of the better off to opt out and take private insurance.

National health services can be prey to access problems that result from inefficiencies in planning and medical auditing: variable quality of service across the same country; differentiated availability of new technologies that supersede older ones in speed, (un)intrusiveness, effectiveness, comfort or after-effects; variable waiting times for the same treatment across the country or for different groups of people. Without free purchase of services by patients or third-party payers and referral systems bounded by geography, national systems find it harder to solve these imbalances. Indeed, inter-regional reimbursement systems to foster cross-boundary flows may actually punish those more efficient institutions receiving extra patients (that treat more effectively) through delays in payment, as was the case in the UK up to the end of the 1980s (Enthoven 1985). This can result in informal discouragement of patients to seek treatment outside their administrative area where such possibilities officially exist.

Further to this, the rise of newer and more expensive treatments for more conditions which one might consider to be not "necessary" (such as cosmetic and fertility treatments) as well as greater challenges to the authority of doctors to take rationing decisions (Ham and Coulter 2000), is leading to various attempts to organise democratic rationing of services available in state-regulated systems. These have generally taken the form of public consultation exercises, usually prior to larger-scale reforms. Limiting what may be available in any compulsory or national health system is problematic insofar as the growth of supplementary voluntary insurance can lead to accusations of creating a "two-tier" system of health, effectively undermining universality.

Costs and spending

There are technological reasons why health care costs usually outstrip inflation across all systems. New technologies tend to cost more than the old ones, so that the cost of treating

the same condition will on average rise from year to year. Previously un- or barely treatable conditions will be treated as cures are found – expanding health care coverage.

But importantly, some systems of financing health can in themselves engender rising costs. Insurance systems in particular suffer from the problem of overtreatment. Unlike most other "producers", doctors can directly influence the buying patterns (preferences) of their customers. Patients rely on them to tell them what treatment they need. Moreover, the patient has no immediate incentive to limit the cost, as it is the insurer who pays. Depending upon the structure of payment (for individual services, for diagnostic group), this can lead to severe inflationary consequences and 'over-treatment' as doctors have financial incentives to offer more treatment. However, state attempts to control costs in social insurance, can be frustrated by the relative independence and strong political power of the managers of the system – often labour organisations and the medical profession (social insurance is typical, after all, of corporatist welfare states) who have interests in keeping costs higher or ensuring full coverage for their members. For example, the Juppé reforms of 1996 failed because of union opposition to such state intervention (see for example Segouin and Thayer, 1999). In these circumstances responsibility for managing the deficits of the health funds is often passed onto the state as guarantor of last resort.

National Health systems have commonly suffered from not knowing what their own costs are, with resources distributed largely according to plan rather than through purchasing. Despite the fact that national health systems tend to be cheaper overall than insurance systems, this creates anxiety about the efficiency of the system (ironically, knowing one's costs can actually increase them through transaction costs and factoring uncertainty about accurate costs into the price). Significantly, attempts to control costs in these systems often result in cutting back on capital investment in favour of current costs - as occurred in the UK in the 1980s (Dean 1993) and was generally endemic in the Soviet system. Indeed, the absence of price-information in national health services makes it difficult to know exactly how much the health service *should* cost to fund. Spending is determined by politics and is in competition with other state programmes. As remarked in the previous chapter, Soviet health sector spending was firmly "residual", although many other East European states were a little more generous. Resulting under-funding becomes endemic by a "same as last year" approach to spending reviews that avoids political controversy. It has been argued by Semyonov (1996:4) that the ring-fencing of health revenues through insurance has helped many developing countries defend health expenditures in times of economic crisis – a position this thesis supports for the Russian case.

The balance between primary and secondary care, and prophylaxis

The World Health Organisation has identified a general historical emphasis on the hospital as the focus of health care, in spite of the fact that primary care institutions (GPs, health centres, polyclinics) are less expensive and more effective as gatekeepers and entry points to any system of national health. However, financing systems can also aggravate this. Insurance systems, with the tendency to increase treatment noted above and their ability to buy services directly from hospitals rather than having to operate through referral systems can lead to excessive investment in and use of the hospital sector. Competition between insurers may also increase investment in glamorous expensive services.

National health systems usually have more effective gate-keeping roles for general practitioners and polyclinics. However, as they are without inherent mechanisms of quality control and thus regulation of output, they have tended to measure the quality of the service by considering intermediate quantitative indicators: the numbers of doctors and hospital beds. This particularly affected the Semashko systems of Eastern Europe, whose communist regimes had a preference for gigantism in construction, and after 1970 a reluctance to talk about declining health indicators. As the Soviet Health Minister Eduard Chazov remarked in the spirit of *perestroika* in 1988, the USSR boasted that it had the most number of doctors per head of population in the world, but kept quiet about being 53rd in the world ranking for infant mortality – the most reliable indicator of health care effectiveness.

There is, in these kinds of system, little impetus to correct problems of co-ordination between primary and secondary care. Berg reports on the Swedish system pre-reform that

> The weaknesses were identified as a lack of integration between hospitals, primary health care...and social services and an over-institutionalisation with too much orientation on hospitals... The limited choice for the patient and waiting lists for some treatments were some of the observed patient-oriented problems. A corresponding producer problem was the lack of incentives for efficiency. (Berg 1998)

As an example of these problems, lengths of bed stays for identical treatments have tended to be longer in national health systems, where improving bed use (and patient throughput in general) actually increases the cost per bed without a concomitant increase in funding to reflect improved efficiencies.

There may also be irrational distribution of facilities (duplication in one region, absence in another), or in the financing mechanisms that allow patients access to facilities outwith their locality – two problems that constantly niggle in Canada (Charles and Badgely, 1999). These problems can result from devolved and uncoordinated planning and finance, or the distribution of facilities in richer areas, or with contemporary investment, in leafy areas on the outskirts of cities.

The focus on curative rather than preventive treatment typical of many systems regardless of type is also inefficient. Proper vaccination campaigns, health education and public health measures are far more cost-effective in lessening demand for health services, but are by their nature less visible in their effectiveness. Insurance systems, often without geographically unified funding bodies, have less of an incentive than national health systems to put forward public health measures; those with private insurance companies especially so. The Semashko systems stand out as promoting public health measures. However, such methods relied upon state ownership of enterprises to allow administration of measures through the workplace that are not possible in a market economy.

Responsiveness, innovation and quality control

Because national systems award treatment according to plan rather than demand (although the former may be formed with estimates of the latter in mind), there are inevitably shortages, which manifest themselves in waiting lists. As a response to the problem of perceived excessive cost, the development of newer and more expensive treatments for more conditions which one might consider to be not "necessary" (such as cosmetic and fertility treatments) as well as greater challenges to the authority of doctors to take rationing decisions (Ham and Coulter 2000), there have been various attempts to organise democratic rationing of services available in state-regulated systems. These have generally taken the form of public consultation exercises, usually prior to larger-scale reforms. Limiting what may be available in any compulsory or public health system is problematic insofar as the growth of supplementary voluntary insurance can lead to accusations of creating a "two-tier" system of health, effectively undermining universality.

Without a price mechanism and supply and demand, national health systems are often seen as unresponsive to the needs of patients, either in terms of developing new approaches, or adjusting to variations in the structure of morbidity in their area. Often local funding reflects historical patterns rather than population need, although with improvements in information, many systems are moving to weighted *per capita* systems. There are also problems with monitoring the quality of treatment. While insurance systems have quality control implicit in the relationships between health care funds and medical institutions, national health systems have to rely upon extrinsic medical audit and monitoring and reporting by their peers. Both methods are unsatisfactory. The first because it measures general quality rather than takes up individual cases, and as it is not essential to the day-to-day operation of the system, it may either simply not exist or be of poor quality. Peer review

within the highly collegiate medical profession is also a weak form of audit that detects only the worst cases of malpractice, rather than possibilities for improved or new practice.

Moral Hazard and infinite demand

In systems where the treatment is free at the point of use some express the fear that people will over-use services – that demand will be infinite if there is no price (see, for example, Miller and Powell, 1967). Furthermore where access is not regulated by price, but by geography and queuing, there can be corrupt practices either in the form of under-the counter payments, common not only in the old state socialist systems and their successors (Lewis 2000; for a detailed analysis of one system see Delcheva *et al.*, 1997) but also in developed systems such as the Japanese (Grishin, Semyonov and Brodskaya, 1997), as well as more informal influence either of social class or personal connection. There is also the risk of "moral hazard"; that people who know that they will get free health care, or have already paid for it, will not make the same effort to maintain their own health and undertake behaviour more hazardous than they otherwise would have done - a preoccupation of the municipal administrators interviewed in this study.

These are broad issues in health care. I turn now to consider the Soviet system in particular, before discussing typical responses to problems in health care, and the appropriateness of the original model for health insurance proposed by the Russian government for reforming the Soviet health system.

The Soviet Health System

As Ryan (1978) points out, the post-war period, at a time when the Soviet Union had established itself as a superpower principally emblematic of the Marxist left, paradoxically saw very little work done on the Soviet health care system, despite its "sizeable and high development" (1978: 1), and its significance as a purported and essentially Soviet achievement. He attributes this to its irrelevance to international affairs and theories of economic development (the dominant discourses regarding the Soviet Union), but also to the lack of much clear data provided by the Soviet authorities regarding governance of the health system. Unlike the post-Soviet period, even those speaking Russian would have found it difficult, it seems, to gather much information. Newspaper analysis and access to more specialist material still provided either anecdotal, overly general or unhelpfully local information. Moreover, the sorts of data that most health systems would surely require, such as morbidity and mortality, were not publicly available until *perestroika*. In such

circumstances the work of Ryan and of Mark Field in trying to establish more than sketchy accounts of the Soviet system have to be commended.

The system's founder Nikolai Semashko, the first People's commissar of Health after the revolution, and a campaigner on workers' health throughout the early revolutionary period, identified as a key element in the Soviet system its uniformity:

> Medical care is not left, as it was before the Revolution, to private charitable institutions, or to private enterprise. The task of the organisation of free, accessible and skilled medical aid to the toiling population of town and country has been undertaken entirely by the central and local organs of the Soviet State...*Thus unity in the organisation of the health service is the first distinguishing feature of Soviet medicine.*
>
> (Semashko 1934: 17 & 19)

Semashko's assessment of health services available prior to the revolution is justified. Late industrialisation created only the beginnings of health care insurance covering a small minority of industrial workers. Country doctors (*zemskie vracha*) who operated as generalists in the smaller towns have been seen as a specifically Russian development. Some in the post-Soviet period look to them as a model to pursue as a response to calls for increasing general practice and family doctors, although given technological change and the lack of material available assessing the work of *zemksie vracha* this appears to be romanticism rather than hard-headed proposal. Although local authorities were nominally in control of health services, in practice the principle of unity implied central control. The localities were free only to conform to central guidance. This element of centralisation that pervaded not only the health system but also the economy as a whole (and which *Perestroika* sought to tackle as central means of population management failed in the mid 1980s), is a legacy which troubles still health care administrators – both those who want to maintain it and those wishing to undermine it.

The second element he draws attention to is "worker and peasant involvement" in health care "fully in keeping with the nature of the Soviet system" (19). In effect this meant that deputies with health care knowledge and interests could take part in economic oversight of the health system, but with no right to interfere with standards in medical practice. An additional part of worker involvement was the encouragement of "health propagandists" in the factory place, encouraging workers to take care of themselves. Such educational projects were lampooned in I'lf and Petrov's comic novel of 1928 *Twelve Chairs*, where the deputy head of the housing committee proudly displays his home-made signs in his office, amongst which were "one egg contains as many fats as half a pound of meat" and "by carefully chewing your food you are helping society" (Il'f and Petrov 1999: 51). In addition there would be much use of film and other media to mobilise the workers to take care of their own

health. The irony is that one of the aims of the insurance system introduced in the 1990s was to tackle a perceived Soviet legacy of indifference to one's own health – part of the problem of *homo soveticus* referred to by Gontmakher (see chapter 3). Of course part of the problem was the contradiction between granting workers control within a system that sought to unify by centralised control.

The third and most well-known aspect was the strong emphasis placed upon preventive medicine. In particular, this meant tackling "social" diseases such as typhoid, syphilis and tuberculosis. Partly this was done as it was done everywhere – by establishing better public sewage systems and the availability of drinking water, attempts to improve housing and so forth. Furthermore, a network of dispensaries was set up that sought not only to cure, but also to investigate the cause of many illnesses. These dispensaries were organised either according to illness or to geographical area, and were empowered to advise on working conditions and health practices in the home. There were also health check-ups in the work-place, as well as vaccination programmes. It is important to remember that the Soviet Health service was born into the conditions surrounding the civil war and emergency rule; cholera was rampant, typhus threatening the stability of the new social order.

Fourthly, larger enterprises contained health care units. This was seen as part of the workers taking care of their own health (after all, officially they controlled the factories), and also as part of the prophylactic approach. These units were particularly charged with examining illnesses associated with that particular workforce and seeking to rectify practices to avoid work-induced incapacity.

Primary care developed along the lines of polyclinics for urban and the more populated rural areas, with medical stations in the more rural areas employing *feldshery* (paramedics) who were able to refer more serious cases to regional hospitals. Polyclinics were established as collections of specialists – for example, divided into cardiology, paediatrics, gynaecology and so forth. These operated much as health centres and GP practices would do in other national health systems: they would either seek to treat you there or refer to a higher-level unit for more complex treatment. Indeed, Ryan (1978) reports a strong emphasis on the importance of specialisation. Expenditure grew to reach around 4% from the post-war period onwards[2]. This fluctuated partly according to the health of the

[2] Measuring health expenditure against various measures of the size of the economy is made complex by alternative methods of measuring expenditure and by the meaning of prices in the Soviet economy. Although I would not go as far as, for example, Anders Åslund in arguing that because of the essential meaninglessness of prices in terms of cost and demand within the Soviet system, and the production of poor quality goods that robbed raw materials of value rather than added to them, figures indicating severe GDP shrinkage in the first seven years of Post-Soviet rule are merely an artefact (Åslund, 2001), it is important to remember that the comparative low pay of doctors (which comparatively

economy, partly according to the demands of other sectors, social spending in essence being a "residual" budgetary item (see below).

Problems in health care in Soviet Health – up to the 1980s

The Soviet Health system was at one time seen by many as one of the major successes of the communist project. As Korchagin notes, in the 1960s "the progressive character of the organisation of Soviet health care was recognised by many countries throughout the world" (1990: 16). Émigrés fleeing other problems throughout the post-war period reported general satisfaction with the state of healthcare, even when living in Western countries with developed systems of their own (Shapiro 1997), findings supported by surveys in the mid 1980s within the USSR (Shlapentokh 1987). In the late 1960s Alexander Werth stated that the health service was "better than either in France or England" (1967: 134). George and Manning (1980) stated, with qualifications, that "The Soviet Health service must be commended as one of the most justly organised and technically adequate in the world".

Its system of state financing and network of polyclinic primary care, combined with an emphasis on prophylactic services and largely free access (patients had to purchase many of their medicines, albeit at low cost) seemed an ideal model in the light of the World Health Organisation's "Health for All" project set forth incidentally in the Kazakh SSSR in 1978. Criticisms of the Soviet system commonly dwelt on the impact of general problems of production upon Soviet healthcare (such as the deficit in pharmaceuticals and poor energy and water infrastructure), and on the uneven distribution of health services between the European centre and the agricultural periphery, as well as the "hidden costs" implicit in free health care, while passing over undoubted improved access in health care over the period of Soviet reforms (*e.g.* Field 1970, 1991), or focussed on the undoubted problems in morbidity and mortality rather than the way in which the health services actually dealt with them[3]. Of course, these were all serious problems, but they are arguably the context in which the provision of health services has operated, and not a reflection upon the structure of health services themselves.

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lowers expenditure figures), the apparently irrational resource distribution between pharmaceuticals, equipment and personnel (which would suggest an unusually large degree of x-inefficiency and therefore inflate the health figures more than in other health services) as well as the general philosophical concerns about the relationship between prices, volume and quality do make using these figures a little problematic.

[3] It is estimated that only between 10% and 15% of mortality rates are affected by the quality (or indeed presence) of medical care; the problems in Soviet mortality appear more plausibly linked with changes in behaviour (increased consumption of alcohol and tobacco) than with quality of health services.

More seriously, however, there were generally accepted problems developing within the health service. It was financed according to the "residual principle", whereby its resources were leftovers from the funding priorities of the so-called "productive sector" and the demands of military expenditure. This separation of health care from ideas of production or costs of labour, argues Korchagin, gave health care the appearance of a 'charitable' act on the part of the state that legitimated the low spending. It made it especially vulnerable to the economic slowdown of the late seventies and early eighties, where cutbacks would come in the health services first of all. It was also victim to chronic under-investment and lack of maintenance: hospitals were commonly dilapidated, and new buildings poorly constructed (Powell, 1992). Schulz and Rafferty note how more expensive equipment such as obstetric ultrasound and electrocardiographs were in short supply even in a metropolitan area such as Kiev (1990: 194). One estimate stated that 200,000 children were dying every year because of inadequate resources and unavailability of more advanced treatments such as bone marrow transplants (Pravda 1990b). The mere fact that health care spending as a proportion of GDP was falling from the 1970s onwards while in other countries it was rising gave cause for concern that unrevealed demand for health care was not being met. Doctors themselves were paid poorly. In accordance with Soviet ideology that privileged the factory worker over potentially bourgeois professions, a doctor's pay was consistently lower than the average manual wage, and falling relatively over time. According to Ryan (1987) in 1965 the average pay of medics was 82% of the overall average for the country. By 1985 this had fallen to 70%.

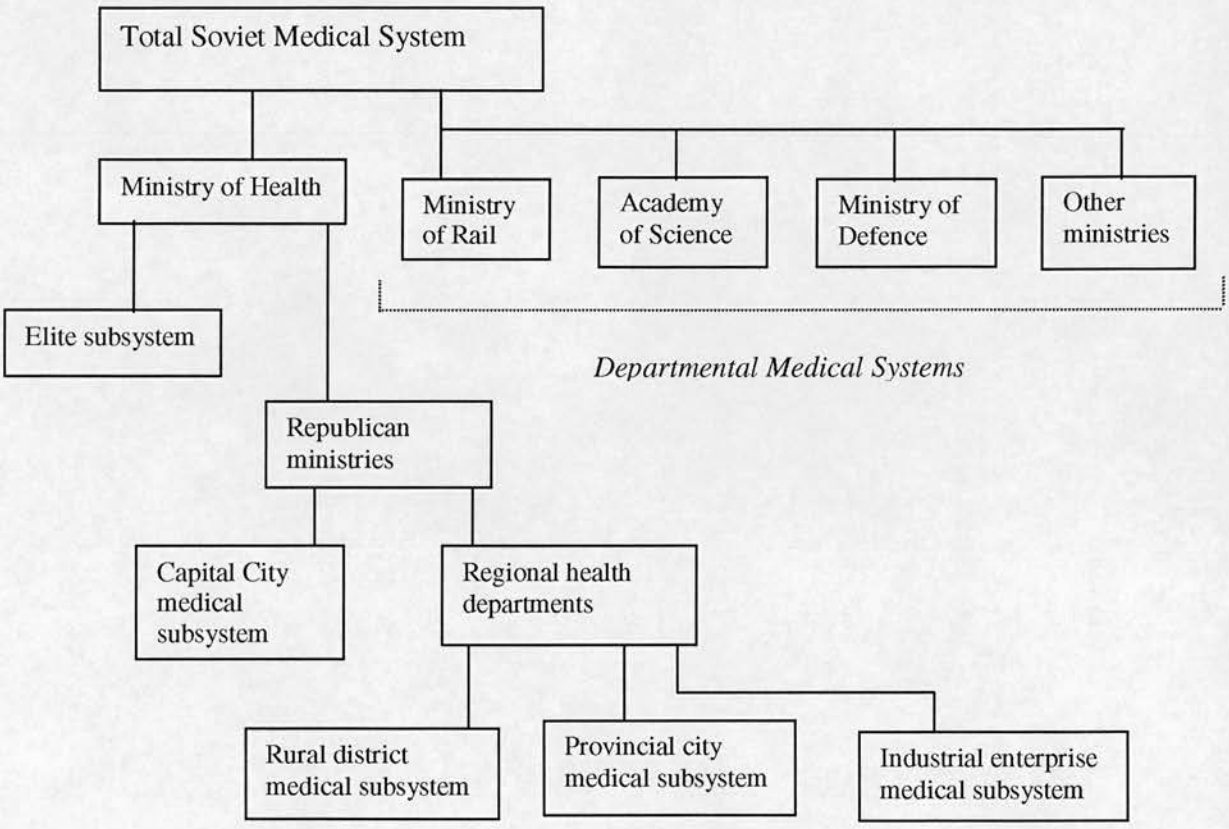
At the same time, the financing structures paid no heed to rational use of resources. There were indications of excessive referrals for common problems, with doctors tending "to make rapid diagnoses and base treatment, sick leave, or hospitalisation on clinical impressions" (Grabbe, 2000:203).

The system's ability to achieve equal access to the whole population was undermined by its fragmented structure (Field 1987; see figure 4.1): there were health services for civilians, for the large ministries such as transport, for the military, health services organised within industry, and the higher service for the party and KGB hierarchy; agricultural health services were noticeably poor by comparison, while the emphasis on health as an industrial resource rather than a social goal entailed preferential treatment for the industrial over the civilian sectors. Field (1987) remarks, "it seems ironic that a society whose original ideological appeal was equality...actually spawned a multi-class medical system". This is a position supported by Schulz and Rafferty who state, "contrary to its stated principles, the Soviet medical care system is neither unified nor egalitarian" (1990:

193). Of course, one needs to keep matters in perspective as to the scale of fragmentation: Ryan (1978) estimates that the civilian system accounted for around 90% of the population.

Efforts to exert central control over the system ran up against bureaucratic conflict and inertia, exacerbated by diffuse authorities for different parts of the health system. "Decision-making tended to be fragmented and the responsible bodies often had inconsistent objectives" (Davis, 1998: 139). Some cities exercised nominal control over their health systems, in smaller ones the health departments were often absorbed into the functions of the

Figure 4.1. The structure of Soviet Health Care (from Davis, 1996)



central hospital. Of course, this contradiction in objectives at the macro-level did nothing to detract from the general strong command structures (the *vertikal'*) within the health system. As the chair of the head doctors association in St. Petersburg reminisced in her interview, "if you didn't fulfil an order, you got into trouble, any piece of paper, you had to give an answer." It is perhaps not surprising that a tracer study in 1967-71 reported by Ryan found that the most common reason given for regional orders (*prikazy*) not being fulfilled in the locality was that the orders 'failed to reach their destination' (1978: 13). Non-fulfilment or alteration of poor policy was far more problematic than simply pleading ignorance.

Evidence was also emerging from the end of the 1970s that Hippocratic professionalism was in decline. "Gifts" and low-level bribery were on the increase (Anderle, 1994), although Field and others saw bribery as possibly a means of patient empowerment. In one notorious article, 500 roubles was cited as the average price of an operation in Baku in the Azerbaijani SSR, as well as the cost of decent treatment in a maternity ward (Izvestiya 1987b) – equivalent to two and a half months average salary. Shuval and Bernstein (1996), studying medic migrants to Israel, argue that "deprofessionalization" (lack of independent professional associations, hierarchical structures, low pay *etc.*) had undermined socialising influences of calling and occupational commitment – which suggests that constraints on "unprofessional behaviour" were weaker than in other countries. It began to emerge that medical records were sometimes falsified to correct mistakes (Buckley 1992:239), not only protecting poor practices but also undermining the validity of health statistics. Psychiatry, famously, was being used as a tool of political suppression, with the Russian Psychiatric Society withdrawing from the World Psychiatric Association in 1984 to avoid being kicked out for its practices. Patient rights also appear to have been neglected in Soviet and Russian health practice (Barr 1996; Richter *et al* 2001), although as Barr points out, this has to be understood in the context of Soviet society.

The quality of medical personnel was also questionable except in the favoured departments of the system, with "few formal quality assurance or peer review activities" (Barr, 1996: 35) to ensure better practice. The head of an institute in Tomsk argued that in addition to indiscipline and tolerance of low standards in medical training, there was endemic corruption in appointments:

> In distribution and placing graduates in jobs, success in school plays practically no role. Practically everything is decided by family situation, apartment, personal and parental initiative and a personal request through the republic ministry for health (Izvestiya 1987a).

Advanced and postgraduate training by comparison with Western opportunities was limited (Barr, 1995), with widespread use of folk remedies intermingled with more standard practice. Grabbe, (2000: 201) gives the horrific example from working as a volunteer in Kazakhstan of a qualified scientist bringing her hospitalised daughter a louse to eat with bread to cure hepatitis[4]. There were problems of dissemination of technological innovations, in addition to poor production standards of equipment (*Ekonomicheskaya Gazeta* 1987). In

[4] One should, however, be careful of snobbery and intellectual imperialism in assessing Soviet medicine. As in, *inter alia*, mathematics and rocket science, its tendencies to autarchic development not only kept many doctors from Western advances, but also Westerners from Soviet. Thus Schulz and Rafferty (1990) report with disgust the recommendation of leeches to cure malignant hypertension in a 1987 Soviet textbook. Not only are leeches now being proposed again as wound cleaners in

addition certain health indicators, which reflected directly on the overall quality of health care, were worsening. Infant mortality, for example, had stabilised at a rate at least twice that of the United States, even allowing for under-reporting.

Crucially, however, until *glasnost'* these problems were rarely discussed openly within the Soviet Union. Indeed, the extent of the problems within the health service that had accumulated was difficult to assess from the outside until the second half of the 1980s. Some of them – such as poor quality training and suspect ethics, are still not raised too much in the media in Russia today; the interview data showed up little concern with it.

In the years following Mikhail Gorbachev's appointment to General Secretary of the CPSU a certain number of specific criticisms arose regarding the development of the health service – criticisms which were often aired most sharply in the press by the officials charged with organising it. In 1987 the Soviet health ministry published something of a discussion paper through *Meditsinskaya Gazeta* in which it claimed health care was the most problematic of all sectors in Soviet public life, in which "as a result of inertia, and lack of clear imagination not only have there yet to be any revolutionary, but not even any noticeable, changes" (MG 25.3.87/1). There was an excessive focus on extensive methods of development that could be traced back to the 1920s, overly centralised control and conservative planning methods, which had stifled independent action and foreclosed the use of material incentives to improve the quality of health care. Intermediate planning targets such as the number of doctors and of beds resulted in the irrational use of resources: in the RSFSR it was estimated that 40% of the recent growth in the bed fund took place at the expense of actually functioning beds; there was a general accusation levelled at all republics that they had colluded in registering beds in hostels and homes as part of their planning targets. For at the same time as the USSR could boast the highest *per capita* numbers of beds and doctors in the world, the technical development and equipping of the health service had sharply stagnated. According to Davis (1998) uneven "extensive" development, had led to construction of medical facilities without central heating and running water, with budget pressures to raise the cheaper intermediate indicators, as well as inadequate storage facilities and insufficient production of pharmaceuticals.

At the micro level there were concerns about the quality of health care being offered, with special emphasis on the incentive structures. The established Soviet system where "the person, the patient, is considered only as a necessary evil, lacked humanity" according to one reformer (MG 13.5.90/2). Commonly quality control consisted of checking that doctors were

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Western medicine, there is serious Soviet, Post-Soviet and Chinese research into the anti-coagulant and hypotensive properties of medicinal leech saliva.

actually at the surgery for the allotted time (MG 23.9.88/2); performance targets were based on anything – numbers of visits, beds occupied, hours of work, level of qualifications – but outcome of treatments (MG 13.5.90/2). Indeed, many such indicators were actually boosted by increased levels of sickness – a "cult of the sick" according to one city head doctor (MG23.9.88). The evidence suggests that there were both excessive referral practices and excessive bed-stays; in the early years of *Perestroika* commonly health care organisers complained of a *deficit* in beds, despite the apparent wealth of places. Doctors themselves, traditionally lower paid than workers in other sectors, suffered, according to the RSFSR deputy minister, from a lack of prestige and trust – both from their superiors and patients (MG 26.8.87).

In short the Soviet Health system paradoxically suffered from underinvestment, overcapacity and excess demand at the same time. It was unresponsive to patient demand, and suffered from over-centralised and yet fragmented control. Semashko's eagerness to encourage a cult of the healthy worker seemed to have failed. Lastly, the quality of medical care was in doubt. These problems are generated partly by the overall social and economic system that it operated in, that demanded uniform central control but a certain class differentiation. Innovation in health care organisation, although recommended by Semashko, became politically difficult. In general and until *glasnost'*, public mass communications were not conducive to criticism of Soviet welfare and analysis of priorities.

What is also crucial to remember as we turn to general issues of health reform, is the context in which reform becomes possible, as covered in the previous chapter. The economy is liberalising, but lacks established institutions to regulate relationships between independent organisations. In general the strength and coherence of central and umbrella social actors has been undermined by the Soviet experience, and the centrifugal forces supported by Yeltsin's leadership of the RSFSR seek to weaken control by the centre even further. The state budget is collapsing and income inequality is rapidly increasing (undermining the state's ability to both achieve and assert social solidarity). Health needs have also changed, as more social diseases begin to rise, partly as a result of the decay of Soviet society, partly as a result of the shock of transition.

Reform of Developed Systems

Problems that arise in mature health systems that aim for comprehensive and universal coverage stem both from structural issues of finance and organisation, and from technological and demographic changes common to most systems. Here I pass over the earlier reforms of the post-war era and focus on reforms in the recent past, from the mid

1980s onwards, considering the general reform tendencies across countries, as a prelude to a discussion of the appropriateness of health insurance plans introduced into Russia in 1991/1993 as a response to system problems.

Reform since the 1980s has broadly been of three types – decentralisation to improve responsiveness, sensitive planning and the connection between financing and provision; micro-economic reforms (usually involving some form of competition) to improve efficiency and quality, and macro-economic reforms that deal with the funding and reimbursement mechanisms[5].

Some countries have sought to decentralise their systems to the local level. As Hunter *et al.* (1998) point out, decentralisation implies a variety of policies, ranging from administrative and political devolution to privatisation of health care providers. In national health systems these measures have been introduced partly to make service more responsive to local demand, which has also motivated the introduction of internal markets. In Sweden there has been an on-going process of political devolution to the county level in health care over the past thirty years or so. Partly this is driven by events from below: hospital boards have begun to co-ordinate district health services in an attempt to integrate primary and secondary care, while budgets have become less itemised and so effectively devolved in detail to the health care institutions. Innovations in market-style internal reforms have also made the county-level administration of health care provision more expedient (Bergman 1998). The United Kingdom has devolved budgets in many instances to GP practices who act as purchasers on behalf of their patients, as well as deconcentrating greater power to the regional health authorities in their role as purchasers – again as part of an overall strategy of internal market reform. In other countries there has been decentralisation in order to correct long-standing inefficiencies in administration. France, for example, has decentralised to the regional level in order better to manage and co-ordinate the relationship (and deep integration) between public and private health-care providers. Previously the central health ministry was unable to respond adequately to local problems (Segouin and Thayer, 1999). However, in developed insurance systems decentralisation is rare; the opposite problem of a national absence of co-ordination often occurs. It is important to note that decentralisation can result in significant variety within the national health system, as has happened in Sweden and also in Russia. Rathwell (1998) argues that such variance, although possibly at odds with the aspirations of equality of access across a nation, could be seen as opportunities to breed new models in local experiments, a sentiment that we shall see is reflected by many in the

[5] Although the point is made in various articles, the explicit distinction between macro- and micro-reforms is here taken from Freeman and Moran (2000).

Russian context. But it is important to remember that this decentralisation process has its limits – the key element is to get as close a fit to the population as possible without losing the health planning advantages of being able to commission for a geographical area.

Some health care systems have introduced various elements of competition and choice. Crucial here is the question of choice for whom and between what. For administrative, structural and political reasons there can be many rigidities in the relationships between the various participants in health care. People may be obliged to go to the doctor or health centre in their vicinity (often there is a theoretical right to free choice, but exercising that right may entail social knowledge or highly bureaucratic procedures, or in itself create problems in the personal relationship between a patient and primary care practitioners). They may be obliged to insure with certain insurers according to geography or profession, or by their insurant (commonly the employer or local authority). There may be rigid referral procedures for primary care practitioners according to geographical proximity or administrative fiat, so that no advantage could be taken of freer resources in other districts. Thus innovations in various systems have been a freer choice of doctor for the patient, as has been the case in most of the post-communist world, or a freer choice of health insurer as has been introduced in countries such as Germany, the Netherlands, and Israel. Competition has been introduced between secondary health care providers for the custom of primary fund-holders (internal markets), such as in the British NHS in the early 1990s and in Sweden in over the whole decade. In this form of competition most significant is the creation of a purchaser-provider split. Family doctors (and group practices) either buy services directly from providers, or regional authorities act to commission health. In either case part of the intent is to separate the interests of health workers (especially their numbers) from the health needs of patients, to prevent any conflation between the two in the minds of planners that often besets national health systems.

The introduction of competition mechanisms is one driven not merely by perceived problems in the health care system, but is part of a general ideological fashion (Glaser 1993). While free choice in various relationships is intended to reduce costs and increase efficiency and quality, it is also a means to empowering patients and their personal health care managers (*i.e.* their family doctor or GP). But it is highly misleading to consider these various extensions of choice as the introduction of proper markets in health care or insurance. As is shown by the example of the United States, true individualist competition usually fails to achieve adequate or remotely equitable coverage (a matter recently covered thoroughly by Jost, 2001). Nor does competition necessarily reduce costs. According to Glaser, competition between providers "raises costs rather than reduces them: research about

competitive hospital markets shows duplication of expensive high-tech programmes to attract doctors and their patients, addition of new marketing staffs, lower inpatient occupancy rates, and higher costs for the entire system" (1993: 807). The marketisation process is usually heavily circumscribed to avoid either this, or to protect either the administrative integrity of the system or the principle of solidarity. For example, in Israel one can move between insurers only once a year; in the Netherlands once every two (Chinitz *et al*, 2000; van den Ven 1997). In Canada private insurance is not permitted for items covered by public insurance. Changing doctors can take a number of days in any of these systems. In Germany following the introduction of long-term care insurance there are strong disincentives to move back and forth between private and public insurance schemes.

Schemes for introducing competition between insurers present a major problem in the maintenance of both equity and efficiency for many countries, resulting in further restrictions and qualifications to competition. In particular there are concerns about "cream-skimming" of healthier (a.k.a. cheaper) patients by funds. When contributions are regulated (for the sake of social solidarity people are asked to pay as a proportion of their income) there will be competition among insurers for healthier, richer citizens. This implies an imbalance between funds in their risk profiles. Furthermore, standardising the contribution rates prevents price signals about the efficiency of the funds from reaching the consumers, while allowing for much variation in rates risks the inequitable access to health on the part of the poor and the old. In many countries there have been attempts to compensate and equalise between funds so that no short- or long-term problems accrue. In Switzerland, which operates on the principle of capitation fees (which may vary between, but not within companies in any one region) there is fund equalisation out of general taxation to correct for demographic inequalities; in Germany there have been attempts to adjust the premiums received by funds to equalise risk whilst allowing minor variations in contribution rates to reflect the relative efficiencies of the funds (Theurl, 1999). These are both not entirely satisfactory solutions, but must be understood within the context of reaching for two contradictory targets.

In the internal market reforms the purchaser-provider split is between state (or public) agencies and organisations, while patients gain no particular rights within the process. Moreover this split usually involves general contracts for service provision rather than buying service by service, with evidence of competition (changing providers, using excess capacity in non-usual units) occurring at the margins. Indeed, what may be a more useful concept in these cases is the notion of "contestable" relationships (Saltman and von Otter, 1995) – where a relationship between participants in health care is stable, but open to

challenge and replacement. Here the stress is not so much on competition but on the availability of ultimate sanction. This is a concept that is perhaps useful in understanding the relationship between Russian Insurance Medical Organisations and insurants, as we shall see later. It is important to remember that competition costs money – in terms of knowing prices, and insuring against the risk of other actors' independent behaviour.

Alongside this increased use of competition mechanisms has come (attempts at) consolidation of the health insurance funds in many countries. The consolidation occurs partly because in the face of competition (rather than captive customers determined by region or sphere of employment) merging makes sense; partly in order more easily to regulate the insurers regarding anti-equity strategies such as cream-skimming. Thus in some systems there is a greater *concentration* of authority, in contradistinction to the pluralist innovations in places such as Sweden and the UK. Consolidation has also been seen as a means to overcome the inequity caused by uneven development in health insurance, such as in Japan (Grishin *et al*, 1997). Consolidation when seen as moving towards a national system of finance reflects the tendency noted above by Semyonov of social insurance and national health systems to move towards each other. It is also another indication of the limits of decentralisation in health systems.

There has also been much experimentation with the details of financing, particularly in insurance systems seeking to limit their budgets. There are inherent problems with funding health care. If it is funded administratively at cost price there is little incentive for efficiency. If it is paid for by the consumer, there is a lack of knowledge on the part of the purchaser (most people are not medical specialists), laying people vulnerable to abuse and quackery. If costs are under-written by a third person insurer there can be problems of over-treatment as the providers milk the insurance fund. While nearly all systems of socialised health care effectively fund purchasers on some sort of demographically adjusted capitation fee (including equalisation of insurance funds), there is variety in how providers are reimbursed, and in who has control of the funds. There has been a tendency in three directions. Firstly there is a movement towards paying for the overall cure of the illness, rather than the treatment. This is most often achieved by funding hospitals according to Diagnosis-Related Groups (DRGs) – as in Sweden's 'Stockholm' model and in Austria (Bergman, 1998; Theurl, 1999). Also insurance companies may seek to pay for individual patients according to their condition, although this is currently rare due to problems of information gathering (Savas *et al*, 1998). Secondly, there is a move towards granting primary care providers budgets – solving the problem of inadequate knowledge and of third party payment. This has occurred in different forms – from encouraging insurance

companies to form networks of GPs in France, to creating fund-holding GPs in the UK, to the strengthening of the system of polyclinics in Greece (Tragakes and Polyzos, 1998). Here there can be problems of equity: carers with different populations will have variable risks to manage. Thirdly there has been an innovation in Germany to solve the contradiction between encouraging more treatment and wanting lower costs, subsequently copied (with uncertain success according to Götting, 1998) by the Czech and Slovak republics. In effect, the overall insurance scheme budget is capped, with money divided among doctors according to the number and type of procedures they have performed in a given year. There is therefore an incentive on the part of individual doctors to treat more. However, the more they treat as a profession, the less the reimbursement for any one individual procedure.

Each of these three elements of reform – decentralisation, internal competition and adjustments to financing mechanisms – is evidence of adaptation of existing systems, of solving extant problems. In very few countries have there been attempts to achieve more than any one of these at any time. Certainly, countries with "mature health systems" have never radically altered the system of financing, sought to introduce greater competition and radically decentralise *all at once*, as was the case in Russia. What can be said about the appropriateness of the new insurance system in solving the problems of the old Soviet one?

The Disconnection between problem and solution

The Russian insurance law planned to create a set of regional systems (covering on average 2 million citizens each), based upon competition between independent insurance companies over employees of enterprises and non-working residents according to municipal authority. Payment methods for services were to be according to agreements drawn up between the insurance company and health care institutions. Health care institutions themselves were to compete for patients. Legal control of health care institutions was to be devolved to the lowest possible level as a rule, with only certain specialist or large units being accountable to authorities higher than the municipality (the large city, or the federal subject, or the federal centre). In principle, despite this "big bang" approach, which in itself might cause problems, the three tendencies of decentralisation, marketisation and consideration of new payment mechanisms seemed appropriate in tackling the deficiencies in the Soviet system. The intense centralisation acted as a limit to doctor autonomy, and demoralised the workforce, while its methods of distributing resources were insensitive to front-line needs. Competition would also help to report inefficiencies, as well as introduce mechanisms of quality control

that were simply absent. The new system of financing through insurance would remove the residual principle from health care funding by a ring-fenced social tax.

However, the 1991 law was not an attempt to mend the Soviet health care system. The decentralisation of control was part of a decentralisation of state property and power rather than of the health care system. The Soviet system suffered from overcapacity: the law on local self-government has made broad rationalisation of resources more difficult. Furthermore, the decentralisation of purchasing was to insurance companies insuring workforces rather than primary care providers caring for a geographical population. As stated above, it is national health systems that decentralise; insurance systems seek to consolidate to overcome co-ordination problems.

The competitive element is confused: for example, both patient and insurer have the right to choose health care providers, while voluntary insurance is supplementary to compulsory universal comprehensive insurance. Furthermore, as prices are (or should be) set for the whole region for all companies, and procedures standardised (replicating the control over medical practice of the Soviet era) the room for competition is not only limited, it actually makes the critical examination of health care systemics more difficult. That the transition era budgetary and legal systems were unprepared for the insurance system to operate is a given.

The financing mechanisms that other countries have experimented with were simply not considered as an essential part of the reform – it was for regions and insurance companies to work out efficient methods. As stated above, techniques such as diagnostic related groups require large amounts of information for data to be usable by insurance companies as bases for risk calculation. Technical support and guidance from the centre has been limited, with regions themselves seeking to establish good practice. According to Degtyarev (writing in 1997) in Russia there were seven different permissible ways to pay for primary care, and four for hospital care. As a result some regions have had to experience the kinds of fee per procedure arrangements that other insurance systems have sought to eliminate. The fragmented purchasing system envisaged inevitably makes reform of practice more difficult.

This and other evidence suggests that the health insurance law as introduced in 1991 (and patched up in 1993) is part of a broader project of the marketisation of social provision (where markets are simply good rather than conditionally useful), rather than a considered response to health care problems, a project founded in a specific economic approach to health care reform.

Russia and the Washington Consensus in Health care

In the previous chapter we saw how an emphasis on marketising society and welfare was a declared priority of the reformist Russian government. The health insurance reforms typified this approach more than any other area of welfare provision. Given the inappropriateness of simple free-market solutions to the provision of healthcare guarantees, how was this allowed to happen?

Straightforwardly, alongside health care debate populated by specialists and health economists, in the 1980s and 1990s there was a parallel approach, sponsored by international institutions, and originating in the same intellectual milieu as both the reformists of the early Russian government and the dominant Western voices advising the change – the so-called Washington consensus. The approach is typified by the following extract from the World Bank's *Investing in Health* document (1993):

> Because competition can improve quality and drive down costs, governments should foster competition and diversity in the supply of health services and inputs... This could include, where feasible, private supply of health care services paid for by governments or social insurance. There is also considerable scope for improving the quality and efficiency of government health services through a combination of decentralization, performance-based incentives for managers and clinicians, and related training and development of management systems. Exposing the public sector to competition with private suppliers can help to spur such improvements. Strong government regulation is also crucial, including regulation of privately-delivered health services to ensure safety and quality and of private insurance to encourage universal access to coverage and to discourage practices – such as fee-for-service payment to providers reimbursed by a "third-party" insurer – that lead to overuse of services and escalation of costs. (World Bank, 1993: 7)

The World Bank usually works with countries without mature health systems; here it is just as much presenting ideal-type systems, as suggestions for improving current ones. One should also note that this is much the only reference made to health care organisation in the entire book.

The problems in this approach should be apparent from the foregoing discussion on health care reform. Competition in supply does not necessarily reduce costs; it tends to raise them. National health systems that have sought to introduce provider competition have done so primarily for flexibility in referrals to cut waiting lists, rather than drive down costs. Furthermore, the active pursuit of competition and diversity can over-emphasise loans and funding to the curative sector away from more effective public health measures (Baru and Jessani, 2000).

The call for decentralisation is vague – it is not stated whether it is thoroughgoing or partial, in management of provision or of purchasing. As a general principle it goes against the findings of a 1992 OECD study of seven countries that concluded that cost containment

was easier in more centralised systems (and a 1993 study of seventeen countries that found no cost benefit to decentralisation), while the WHO's European members counselled against excessive decentralisation in provision and in favour of regional networks because "they are more cost-effective, allow for better organisation of the response to medical emergencies and facilitate co-operation between hospitals and primary care" (WHO 1996: 1665). It also emphasises the curative at the expense of public health measures.

Equally vague is the call for "performance-based incentives and management training". On one level it is anodyne – encouraging medical personnel to work "better" – undeniably a good thing, but meaningless as a strategy. On another level it implies the preferential funding of those units that perform better, either through improved technology and conditions at work, or through higher pay. However, the mechanisms by which this could be achieved are manifold, and none is specified within the document. Should it be incentives provided by the exercise of primary care choice within an internal market or managed care? Should it be through the exercise of medical audit by insurance companies, extracting fines? Is it no more than increasing state audit of hospital care and more rigorous internal assessment, along the lines of general management in the British NHS? (Harrison 1995, Light 1999) These are big questions that are intrinsic to system choice rather than additional matters. They also impact upon the Soviet medical heritage. Outside control of medical practice is an innovation in itself, while consumer control of a medical profession whose consideration for patient attitudes is culturally weak (Richter, Eisemann and Zgonnikova, 2001; Barr 1996) is also a questionable strategy.

Fourthly, the suggestion that competition from private practices will benefit the public sector ignores the realities of private health care alongside a sizeable state system. Private providers tend not to compete openly with state providers. The latter may be subsidised or free (which *could* possibly be compensated for through vouchers, tax reliefs and so forth); are often structurally under-funded, abiding by inflation-unresponsive centrally-set tariffs; and/or operating across a large structural-geographical area without explicit intra-system costs that would inflate external prices. Thus competition on cost is often difficult. This was the case in the early attempts at self-financing independent health co-operatives in Russia (see next chapter). Markets for private care thus tend to be segmented, focussing on the wealthy and competing on "hotel" services and non-vital treatments. Furthermore where the private sector has an opportunity to provide better working conditions and pay, it could commonly lead not to increased investment in the public sector, but the depletion of a mobile factor of production – labour – enriching the

private sector *at the expense of* the public sector – currently a problem within the British NHS.

Of course, private provision might flourish under conditions of a general reform of the internal financing of health care – the thorough introduction of a provider-purchaser split and an "internal" market, demanding that all units are broadly or largely self-financing, with regulated tariffs *etc.* These circumstances would provide a "response" mechanism for state organisations to competitive pressures, but would demand greater centralised funding to lower the impact of catastrophic risks. This does not seem to be their recommendation.

The emphasis on strong government regulation ignores the reality of many client countries – both in Eastern Europe and the developing world. Many suffer from weak state authority and law, including non- and prejudicial (corrupt) enforcement. As we saw in the previous chapter, such problems can be exacerbated by IMF restructuring programmes that have tended to neglect institution building (including tax and regulation agencies) in favour of formally liberalising economic conditions. This is true both of post-colonial (Sen and Koivusalo, 1998) and post-Soviet countries. It appears to have taken some regions in Russia – including Volgograd Oblast' in this study – a number of years to stabilise the insurance organisations in the face of both parastatal and commercial corruption. The issue here is not that one should not have government regulation, but that this regulatory approach – using arms-length "governance" as a strategy for managing public services – in such regimes requires the extra development of complex institutions in a context of weak institutional operation.

Lastly the use of private insurance (even under regulation) to ensure universal access is actuarially incredibly problematic as there is a strong inverse relationship between health needs and relative income, which has led most industrialised countries to seek some form of compulsory state-regulated health insurance or funding from taxation (Jost 2001). It is also difficult to prevent cream-skimming of the healthier patients either through price, location, targeting of certain groups or informal personal discouragement; thus access can vary through variations in price and coverage. It has been one of the main difficulties in the stalled Dekker reforms in Holland to avoid precisely these perverse incentives (Björkman and Okma, 1997; de Roo 1995). Again, the institutional weakness of many client countries (and especially of the former communist regimes with limited commercial and institutional law frameworks) militates against implementing such solutions. The Russian Law of 1991 presumed the natural growth of a private, voluntary health insurance market, without putting in place the necessary structures for such growth. Indeed as chapter 8 details, the finance

ministry was quite unprepared, and had to be taught by the insurance companies how to administer and regulate them.

In short, the Washington consensus on health "is based upon two complementary principles: the reduction of state intervention and public responsibility, and the promotion of diversity and competition (*i.e.* privatization)" (Laurell and López Arellano, 1996:1), with only a mild consideration of the difficulties such policies have encountered in the developed world, and with excessive expectations of the institutional structures of client countries – who by definition suffer from institutional weakness. The insularity of this debate has been recognised by Buse and Walt, who note that

> In spite of its reputation for analytical competence, [the Bank] may not be sufficiently open to debate, critical self-analysis, or external review. One result is that Bank statements in the sector have tended to de-emphasize complexity and uncertainty, and to present policy prescription as received wisdom, with...attendant operational consequences. (2000: 178)

Indeed, as Deacon (2001) remarks, the IMF and World Bank "NEVER" [his capitals] expose their recommendations to peer review. According to Banerji (1994), a World Bank team working with the Indian Government on health reform contained no health reform specialists, but a number of non-specialising economists. In line with the dominance of economics as a discipline, 'perhaps unsurprisingly, the battles within the Bank between economists and public health and other specialists have to date been won by the former' (Buse and Walt 2000: 177).

The Russian Law on Health Insurance of 1991 and the reform of local government displays all the characteristics of the Washington consensus: independent insurance companies working both with compulsory and voluntary insurance, management of health-care units decentralised to a very low level, the encouragement of private practice (the law repeatedly emphasises the irrelevance of health care unit ownership), as well as subsequent proposals to privatise health services. Despite amendments in 1993 that allowed many regions to ameliorate the proposals, the Russian health system has indeed suffered from problems of governance and co-ordination, from institutional under-regulation and corruption, with only marginal success at re-balancing primary and secondary care, and with a near collapse in many public health measures. All these problems have originated in or been exacerbated by the pursuit of the broad principles outlined in the *Investing in Health* extract. One of the main arguments in this thesis is that the emphasis on "marketisation" has been damaging. This is certainly not an attack on the use of market mechanisms in health care *per se*, but a criticism of the concept as the driving motive for reform.

Policy transfer and health reform

The mediation of Washington consensus thinking in health into the Russian debate is not entirely straightforward. Proposals for insurance that became the 1991 law were drawn up by Soviet economists (Kisilev *et al.* 1990). Curtis *et al* (1995) state that insurance had originated with broad support from the medical profession. Meanwhile Shishkin (1995) suggests that the implementation of reforms was held up by conservatism in the health ministry (whose officials are drawn from the profession), while contrarily later (1998) asserting that insurance had found a receptive audience with predominant liberal progressives within medicine and the political administration. Interview data from this research and *Meditsinskaya Gazeta* archives support the view that insurance was sold to medical officials from above, primarily as an additional source of expenditure. There is in fact little evidence of it as an idea that had common currency before central reform plans were being finalised.

Regarding international influence, Russia was not granted membership of the IMF and World Bank until April 1992, with no World Bank grants specifically for health care until 1997 – for the reform of health in six oblasts (World Bank 1997). Yet crucially, according to one Volgograd respondent in this study who, as luck would have it, had been a member of the Supreme Soviet committee revising the law in 1992, the World Bank *had insisted* on the introduction of a pluralised form of insurance, a claim backed up by another respondent in the same site who spoke of secret Bank "protocols" (it is probable that this second claim originates with the first respondent). In general respondents for this study had come to feel that the move to insurance was part of general marketisation: what Kosmarskii and Maleva (1995) see as the reformist requirement that all sectors of the economy should conform to this new mode of production. That is, the rather neo-liberal insurance proposals (bound by constitutional guarantees to health care) were derived from general processes of marketisation, rather than originating within the profession.

The relationship between the World Bank, the IMF and the early Russian government is more subtle than it might first appear. Problematically for analysis, the nature of any technical assistance in these early years that was not attached to loans is hard to come by, as the World Bank publishes details of only even *some* fact-finding missions, let alone documents used in negotiation with governments (Žarković and Satzinger, 1997: 261). However, two years before Russia became a full member, it was certainly receiving technical support. According to the Bank's European director Eugenio Lari

> The bank is indeed departing from standard practice in offering its assistance to a country that is not a member. This marks a new stage in the development of the contacts we have already

established, contacts that I am certain will be crowned with full Soviet membership in the World Bank.

Izvestiya (1990b)

That is, Russia was being given guidance on how to accede to World Bank membership. In effect, it was given conditions for being considered as a possible recipient of conditional loans some time in the future (Prime Minister Yegor Gaidar was forced to defend this process by stating "We do not intend to work to the direct dictation of the IMF. We do not share the views of this organisation on everything, and we will stick to our present point of view" (*The Independent* 29 April 1992, cited in Sakwa 1996: 239).). However, Sakwa suggests this was making a virtue of necessity: the government could not comply with some of the stabilisation requirements. As argued in the last chapter, institutional resistance to reform in welfare was far weaker.

The over-obedient attitude of the Russian government towards Bretton-Woods institution recommendations increased the latter's influence: Labour Minister Aleksandr Shokhin declared in 1991 that Russia must "really prove that it is capable of proceeding down this path [of reform] energetically and independently" if it was to gain economic assistance from both the IMF and World Bank (*Rossiiskaya Gazeta* 1991). Williamson (2000) argues that former Soviet countries mistook the IMF and World Bank full-blooded neo-liberal proposals as the only choice on offer, rather than as an opening gambit in a process of negotiation. In the aftermath of the financial crash in 1998, the social-democrat politician (and former economist in Gorbachev's last cabinet) Grigorii Yavlinskii characterised Russia's interaction with the IMF thus:

Other countries go to the International Monetary Fund with a programme, and ask, "will you give us money to support this programme". We go to the International Monetary Fund and ask them "what do we need to do to get money from you?"

(Radio Svoboda, September 1998).

The generality and vagueness of the law is also possibly a reflection of World Bank influence. As argued above, Bank advice in the early 1990s tended to shy away from the kinds of complexities that are the necessary stuff of health care reform, and this, according to Žarković and Satzinger (1997) was especially true of advice to Eastern Europe. There was also a tendency not to tailor their marketising proposals overmuch for each country – which Banerji vituperatively labelled "intellectual fascism" (1999). Partly this results from the theoretical approaches of advisors. In Prime Minister Yevgenii Primakov's memorable phrase "It irks me when delegations made up of young boys, who, not knowing life and conditions in our country, begin to dictate or recommend this or that scheme". Partly it

involves the working practices of the World Bank that undermine consideration of country conditions. As Pavignani noted with regard to Mozambique:

> The visiting team was very knowledgeable of the country's needs and health policies, and openly supportive of them. Unfortunately, major decisions were taken in Washington, by the Bank's distant and rather arcane management, sometimes against the visiting team's advice. Hence, some documented and justified proposals have been turned down by headquarters, because of abstract policy considerations, easily dispensable if local realities had been considered. Significantly and perhaps symbolically, it was the Government of Mozambique team that made the trip to Washington in order to conclude negotiations for the present Bank loan to Mozambique. Perhaps the Bank is aware that the term "client" originally meant "dependant". (2000: 181.)

Against this Wallich (an employee of the bank) asserts that 'the World bank strategy and support differs from country to country, and is tailored to each country, based on individual needs, the stage of transition, and the state of the economy' (1995: 59). But this does not answer the charge; it reinforces it. It is not that policy recommendations are exactly the same in terms of *what to do next.* It is that policy is determined by resolving the dissonance between the current state of affairs and the ideal type.

However, although with all this circumstantial evidence as well as first-hand testimony, it is very likely that something akin to the "secret protocols" existed, it is not enough to lay the blame solely at the door of the international agencies. Simply put, the liberal reformers within government held a deep intellectual affinity with their Western advisors. Gaidar once quipped to the Congress of People's Deputies "I am not going to waste your time trying to convince you that no agents of international imperialism or foreign spies have gathered in the government" (*Rossiiskaya Gazeta* 1992). With their connections to Anglo-American free-market think tanks, they were aggressively pro-Western and neo-liberal, and inclined to the theoretical. Lloyd (1998: 217-8) notes their absolute refusal to treat Russia as a "special case" economically and temper their blueprints, suggesting an insensitivity to the conditions of the country they actually governed that easily matches that of the international institutions. Their rapid influx into government at the beginning of the decade undoubtedly gave a health insurance system designed to encourage competition and consumerism a good reception, unencumbered by practical considerations of institutional development.

Further deepening the process of policy transfer was the importance of precisely these smartly dressed reformers who spoke good English to successful negotiations with the Bretton Woods institutions. During the mid-1990s it appeared that success with the IMF was almost entirely dependent upon the presence of Anatoly Chubais, the member of Gaidar's Gang to remain in executive government longest, in the negotiating team. These informal

elite social relationships that reinforced the liberal stance of the government should not be underplayed. From Lloyd again:

> [Yeltsin] was still to be counted on for broad economic change; he was enfolded into the club of major world statesmen, to whose pressure he would often bow in the matter of retaining liberal ministers or passing pro-market legislation. (1998:39)

Thus while these reformers were generally far more occupied with matters other than health care, their control of the broad political agenda, willing acceptance of the general dictates of the Bretton Woods institutions and control of the economic ministries ensured that alternative proposals to abandon health insurance were unlikely to find favour. Every subsequent (and usually abortive) intervention these ministries made into health care was based around the project of privatisation and competition. The corruption and lethargy within the health ministry (detailed in the next chapter) certainly offered no effective resistance, despite its early opposition to health insurance.

Decentralisation, while part of the Washington Consensus agenda, would have occurred anyway. As noted in Chapter 3, part of the anti-Gorbachev and anti-Soviet strategy pursued by Yel'tsin was to encourage demands for decentralisation from ethnic republics. His subsequent desire to maintain the Russian Federation entailed giving regional and local governments great control over resources across all members of the Federation, "ethnic" or not.

Conclusion

That which experience of international health reform would suggest for improving the Soviet system, and the proposals put forward by the Russian government in the 1990s have little in common. In particular, the latter appear to emanate more from an ideological position than from consideration of practical matters. Driving this was a coalescence of forces inside the Russian government and assisting it; whose confidence in neo-liberal models encouraged them to treat reform in general as a theoretical exercise. For them, health reform was about creating the "correct model" rather than improving the operation of the vast infrastructure of a mature health system. The correct model was in effect the correct framework of regulation, within which various agents of consumer demand and health care supply would somehow sort it out for themselves. The experience of health reform in other countries suggests this is not possible, that detailed state legislation and tinkering is necessary to support relationships; that purer markets tend to deliver worse results; and first and foremost "intelligent" reform should be based upon improvements to existing systems.

Resistance to, and inertia in respect of this agenda is found in the regions, where the lack of growth in insurance companies necessitated changes to the 1991 law. These allowed greater (quasi-autonomous) state involvement to underpin the system's growth. Regions have used these new powers to create a large diversity of systems; some are quite close to the original design, while many others are far more socialised and monopolistic.

Health care reform in Russia is thus best understood as a set of regional responses to the central imposition of an entirely new system of financing, a system which has its origins far more in liberal economic theory than in empirical analysis. The second half of this thesis explores this diversity, and in particular the responses of two regions.

5. Early Reforms in Health Care and the introduction of Compulsory Health Insurance

In this chapter I review 1980s reforms to the Soviet model of health care, and the genesis and enactment of the compulsory medical insurance system. As Davis (1995) states, reforms in the health system "did not begin in the 1990s with the arrival of consultants from the World Bank and Western aid agencies" (p. 140). The problems that accumulated in the Soviet health system over decades prompted a variety of responses in the seven or so years before the eventual adoption/enactment of health insurance. Some of these responses in their piecemeal failure led to calls for more wholesale reform; others in their success however partial were seen as the foundation for the broader changes that followed.

Initial reforms

In one sense the Soviet health system was just one more problematic part of an advanced command economy. As state in chapter 3, the Gorbachev-era health reforms were very much part of the *Perestroika* programme: incentivising and decentralising, giving those running health care at the local level greater freedom of action, and local authorities greater freedom to organise. Indeed, the initial conservatism of health care organisers in the face of *Perestroika* was bypassed by introducing three innovations from the broader economic reforms: co-operatives, brigades and *khozraschet*.

In 1987 new laws allowed the formation of "co-operatives", organisations allowed to operate in what to all intents and purposes was a capitalist manner: renting property and equipment from the state, so that they could utilise both spare capacity and demand to sell products and services to the population. Writing at the time, Phillip Hanson called the 1987 law "perhaps the boldest liberalizing legislation on the economy proposed so far under the Gorbachev leadership" (1992: 158). It was an attempt by Gorbachev to "meet pressing consumer demand" and displace the black market (Nuti, 1992)[1], as well as improve workplace democracy. Medical co-operatives were groups of doctors who were permitted, outside of working hours, to render services to patients for which they could charge. (Co-operatives could also touch the sector in terms of medical equipment production and pharmaceuticals). The intention was to make up the shortfall in services provided by the state system – or, as it tended to be more acceptably phrased so as not to admit of such problems, to "widen access"

(*e.g.* MG 30.12.87/2) – as well as bringing in extra resources from other organisations and private individuals[2] (MG 25.8.87/2) to overcome structural funding deficits. Co-operatives also presented opportunities for medical workers to increase their earnings dramatically –at the end of 1989 reported as approximately 50% more than the average pay of a state medical employee (MG29.12.89/2). (However, Nuti (1992) argues this was partly the result of problematic ownership rules: the individual members of a co-operative had no personal stake in an organisation owned collectively by all members, present and future. There was therefore an incentive to transform any accumulated capital into wages.

The response to the co-operatives was mixed. They certainly grew swiftly – by the end of 1989 there were 3,000 offering medical services, with 900 alone in the RSFSR appearing that year (MG 3.11.89/2). At the central health ministry they were seen as a key element in the general reform of society; already by the middle of 1988 they were officially encouraged by the union health ministry in a whole host of specialisms, although certain areas – such as oncology, STDs, drug rehabilitation, abortions – were discouraged (MG 20.5.88/3). Despite this they also met with resistance from various levels of government as well as from many within the profession. Some elements in the health ministries themselves were apparently frustrating co-operative development. For example, a 1988 Union directive limited the activities of medical co-operatives (Powell 1992). Shelley (1992) reports general fears at ministerial level that the co-operatives were taking resources away from the state system in terms of personnel and equipment, and Powell cites evidence that some co-operative doctors were turning away their state sector patients in order to bolster their private work. By the end of 1989 the ministry made no mention of co-operatives as part of health service development (MG 29.12.89/2), despite previous projections that official "pay medicine" was to increase fivefold up to the year 2000 (MG 4.9.87/2).

At the local level there were concerns about control over co-operative activities. Licences were apparently being granted by local ispolkoms[3] without much oversight (MG 29.12.89), while prices were too high effectively to increase access for the whole population. Local authorities unwilling to relinquish control over health resources often tried to extract bribes and used frustrating regulations – after all, co-operatives were often renting property from these very agencies. In general credit facilities available to co-operatives in the gift of the local authorities were also often limited to purchases and not to capital investment

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[1] It should be pointed out that co-operatives were originally a policy of Lenin's, largely removed under Stalin and then Krushchev.

[2] According to the Soviet Health Ministry, these sources could be from newly formed "health funds" designed to invest in the system, bank credits, trade union social funds, private savings and hard currency from resident foreigners (MG 25.9.87/2)

[3] Executive committees. From ***ispol****nitel'nyi* ***kom****itet*.

(Colton 1991: 80). Those working in the state system, according to the union of medical co-operatives in Donetsk, often refused to consider results of consultations in co-operatives (MG 3.11.89/2). The union health ministry reported a psychological reluctance to introduce financial incentives for doctors to improve their work: for many working harder for money ran counter to improving care for patients. Brudny (1991: 177) reports that Russian nationalists in the late 1980s condemned co-operatives as part of the "cultural pluralism" that Gorbachev was introducing. However other anecdotal evidence suggested that the lack of incentives had created, in the words of the head of Kirov *raion* in St. Petersburg ten years later, a disregard for patients similar to that shown to customers in Soviet shops – a work burden with no reward.

Quite apart from cultural, institutional and political resistance to the development of co-operatives, they also appeared to create problems for those remaining within the health service and beyond. Not only, it was argued, were the best doctors leeching into the co-operative movement, there was evidence to suggest that through their financial muscle they were exercising first call on vital resources, especially pharmaceuticals (MG 29.12.89/2), as well as diverting capital resources from what had become a dilapidated system. Co-operatives making medical equipment often switched to making more profitable goods. Straightforward corruption occurred: co-operatives often formed around the heads of certain institutions who then failed to enforce payment to that institution of the rent for equipment and premises. In general the dramatic increase in wages of the whole co-operative movement, as well as the strain on underdeveloped state credit agencies created suppressed inflation (Izvestiya 1991a; Rutland, 1997). Co-operatives were also at the centre of investigations into organised crime, both as victims of extortion and protection rackets, and as a means of laundering money (Hewett, 1991: 123).

In essence, the co-operative movement in the health services was faced with a contradiction. Health care was provided on the residual principle of funding. There were bound to be shortfalls in production. It made sense to allow organisations and individuals to sell goods and services in order to make up that shortfall. However, within the system health care was artificially cheap: doctors were on low wages, goods and equipment were commonly produced at or below cost-price, insofar as costs could be known. Anyone trying to provide health services outside that system was bound to charge a higher price for any services because they had to cover their 'real' costs in a way which the health service, planted in the middle of a command economy, did not. It was therefore inevitable that to activate extra resources (suppliers) from outside the system entailed paying a much higher price for these extra health services than the apparent (bureaucratically determined) cost of

the state system. Thus meeting any shortfall would cost more than would be expended in the state system. Furthermore the co-operative movement, as it developed, attracted resources from the state system. Unless the improvement in resources allocation and work incentives were to reflect the increase in cost, the development of co-operatives was bound to make the cost of health care higher where they operated, or starve it of resources. In the context of a stagnating shortage economy they were bound to create institutional resentment. Furthermore it becomes obvious that they would not have been able to make a great impact upon the problems in health care without wholesale reform of financing mechanisms that would allow the proper costs of production for all to be revealed.

It is also striking how vulnerable co-operatives were to authority. The flagship co-operative *Lechenie i Konsultatsiya* (Cure and Consultation) was eventually closed down by Moscow city authorities who exercised the rights over the lease of their buildings to make the co-operative uneconomic (18.3.90/2). By 1991 and the movement towards health insurance, it was written in Meditsinskaya Gazeta that we had somehow "forgotten" about co-operative medicine (MG 8.2.91). Their number was in decline (Powell, 1992), falling by a quarter in the RSFSR between 1990 and 1991.

However, despite the reform focus moving away from co-operatives it is important to recognise what it was that they represented in terms of responses to perceived problems in Soviet health care. They were an attempt to create decentralised health care institutions with the freedom to distribute resources rationally and with the incentive to do so. They also reflected an attempt to increase the resources going into health care – both in terms of capacity and in encouraging private and enterprise contributions – to overcome the inheritance of residual funding. This approach found later echoes in the emphasis placed upon voluntary insurance as a means to increase funding in the later laws. They were also commonly cited as part of the general move towards a "(regulated) market economy": they were ideologically agreeable – a characteristic which later recommended (or explained the necessity of) insurance to many respondents and analysts.

An alternative workplace reform was the "brigade". Groups of workers *within* organisations could form a brigade and tender its services for a specific fee – a practice developed in the late 1970s in agriculture and construction (Dyker, 1992). This approach escaped the general inflationary tendencies of the co-operative movement insofar as it aimed to improve efficiency broadly within the existing wage cost structure. The brigade reflected two elements of *Perestroika* – the proper democratisation of the workforce as part of

decentralisation, and, according to party documents "the eradication of the equalising tendencies in pay" (MG 22.1.88/2) – *i.e.* the need to incentivise better work.

Although in principle this form of "contracting out" could achieve efficiency savings, it had to deal with three particular problems. Firstly, the absence of competition which particularly plagued a poorly planned health service initially suffering from shortages rather than spare capacity *per se* (MG 29.5.87/2) created the impression that brigades were simply devices for making money (6.1.89/2). Secondly, the financial structures in place meant that whenever economies in service were achieved and not devoted to wage increases, funding was often cut by that amount – effectively punishing the efficient (MG 18.3.88/2) – a practice put down to misunderstanding the purpose of brigades. Thirdly, in the absence of quality assurance, there was an incentive to economise on the quality of service offered – and commonly opposition to brigades was expressed in these terms. Institutionally, the use of brigades to encourage greater workplace democracy brought resentment from the trade unions, which sought to frustrate them. This is in addition to a general lack of protection of their rights as workers (Hauslohner, 1991).

A third piecemeal reform was the extension of the *Perestroika* principle of *khozraschet* to institutions within healthcare. *Khozraschet* – which simply means "economic accounting" contained within it the principle of *samookupaemost'* – being able to finance oneself through exchanges with other organisations. These reforms were designed not only to encourage microeconomic efficiency within organisations, but also to help rationalise production across the Soviet economy by removing the emphasis on crude output, the co-ordination of which had undermined attempts to improve quality (Rutland, 1990). Partly using brigades internally, the main mechanism was buying from and selling services to other organisations and individuals through a set of tariffs agreed, in health services, by the local authority. Efficiency gains would be achieved through discouraging excessive (and expensive) referral practices, rationalising existing resources (such as the bed fund), and innovating – the sought after intensive (as opposed to extensive) development of health care. Institutions could adopt this method of operation on a voluntary basis. According to the Union health minister Eduard Chazov in 1989 requests were arriving almost every day.

However, although khozraschet clinics were one means of strengthening primary over secondary care and thus correcting the pro-hospital bias that decades of focus on intermediate indicators and architectural symbolism had created, they still suffered from their interaction with the authorities. The tariffs set by some local authorities bore no connection to the cost of services, making khozraschet unworkable (MG 7.10.87/2). As with

co-operatives, the loss of control over healthcare resources also created tensions with local authorities. Often therefore *khozraschet* became simply a by-word for a pay clinic, as only those able to charge adequate rates could survive. Credit facilities for khozraschet organisations in general and other institutions were also limited. As a result there were imbalances between cash-rich and cash-poor institutions further exacerbating deficits and suppressed inflation (*Izvestiya* 1991a).

Central to the inability of each of these innovations successfully to solve the profound problems in health care was their operation within the context of a distributive system that emphasised residual spending and rationing by queues. Any attempt within such a system to economise was to be unrewarded, or unfairly enriching, or to create perverse distributions of resources. As Rutland put it "we see the paradox of reform in a [centrally planned economy]. Unless *all* the rules are changed at once, reformers may be penalised – but how can one expect everything to be changed simultaneously?" (1990:180). Indeed, the key reforms which appeared to be successful were the "large scale economic" experimental reforms in three areas of the Russian RSFSR – in Leningrad, Kemerovo Oblast' and Kuibyshev Oblast'.

The New Economic Mechanism in healthcare

> If we had continued with the organisation of health care that was initiated in 1987, the New Economic Mechanism, it would have had a chance to develop, and the insurance mechanism would have overlaid it very well.... In our country we all greatly suffer from a lack of continuity – both in social and in economic policy.
>
> Head of health care, Vasiliostrovskii *raion*, St. Petersburg

Although in 1988 Soviet health minister Shchepin declared that the government had examined the health reforms being enacted in the UK and rejected them for fear of creating perverse economic incentives (MG 6.1.88/1), the experimental system of financing introduced into Kemerovo and Kuibyshev Oblasts (the latter now called Samara) and Leningrad city bore all the hallmarks of the UK system of fund-holding. Introduced on January 1 1988 as part of the *General Directions in the development of health protection of the population and the reconstruction of health care in the USSR in the twentieth five year plan and up to the period of 2000* (published MG 27.11.87), the experiment involved a radical change in financing and organisation. In each territory polyclinics were given funding according to their patient rolls (determined territorially), with which they purchased care from other institutions as they saw fit, with all institutions operating on *khozraschet*

principles. Tariffs were set by the authorities, which eventually moved to a form of Diagnostic Related Groups assessment of treatment cost (numbering around 3,000 in all) (MG 22.6.90/2).

These reforms sought to tackle most of the major problems in the health care system identified in the discussions leading up to the *General Directions*– costing treatments that allowed movement away from residual financing of health services; to allow freedom of action for those in charge of health care institutions, and for the regions above them to liberate themselves from bureaucratic central control; to allow the development of systems of incentives for doctors and institutions; to achieve a clear separation of primary and secondary care, allowing the emphasis to be shifted onto the former rather than the latter; to provide structures for standards in quality of care to be enforced (report by Eduard Chazov MG 25.11.87/1). Unlike the normal khozraschet pay clinics (and later health insurance companies offering voluntary coverage), who could tap private demand and bring resources into the health services, these reforms were not designed to tackle residual funding directly, although the process of costing health services would allow more accurate assessment of expenditure needs. Residual funding was seen as a problem of political will – which as we saw in Chapter 3 was being resolved by leadership emphasis on social needs.

The reforms themselves were implemented with inadequate legislative, educational or normative preparation – presaging problems associated with implementing insurance six years later. A common complaint, especially from Leningrad, was that doctors were plagued by a "lack of knowledge" of the system, and of economic methods of management. Per capita financing was initially crude; failure to take into account the age and gender structure of the population created problems for the maternity services in one area of Kemerovo Oblast' (MG 6.9.89/1). Payment systems had to be developed after the system began. Quality indicators were introduced only in the second stage of the experiment, at the beginning of 1989. Prior to that fears were expressed, that as with brigades, there were incentives to sacrifice quality of treatment for quantity. Even after their introduction, these quality standards were not enforced adequately. The Ministry of Finance and its regional departments appeared to be "putting a wheel in the spokes" of the Kemerovo experiment (MG 9.8.89/2), resenting the new financial power of the polyclinics (MG 27.4.88). These problems – a lack of preparedness and understanding on the part of medical workers; an absence of guidelines or sample norms provided by the centre; failure to enforce quality; a lack of co-ordination and comprehension between central ministries – were to haunt the introduction of health insurance as well.

Despite these problems, the reforms themselves were judged successful enough to broaden to a further twelve regions of Russia. Although one of the reformers himself found the reaction of the Ministry of Health care a little too "euphoric" (MG 9.8.89), it is worth reviewing what was achieved, and why might administrators in St. Petersburg generally have spoken favourably and preferably of this period of reform. The authorities in Kemerovo and in Samara are also attempting to reintroduce many mechanisms of this period, notably strengthening the role of primary care control of resources (*e.g.* MG 25.8.95/11)

Some of the main inefficiencies identified in these reforming years were tackled. In all three areas the bed fund was successfully cut, although sporadically throughout each region. Bed-days were also reduced, as indicators of outcome rather than process were developed (MG 16.3.88/2). Referrals were thus reduced, although there was some evidence of low referral due to lack of understanding of the real costs of treatment elsewhere (6.1.89/2). Recruitment, it was reported from Kuibyshev had been improved and rationalised by liberating unit managers from central appointment systems (MG 18.5.88/2). A clear separation of primary care and secondary care was achieved, in preparation for the long-declared aim of introducing general practitioners in place (at least in part) of the complex profile of specialists that usually populated a polyclinic.

Particularly notable is the potential that the reforms provided for organisational innovation. In order to preserve the integrity of the health system in any one territory, it quickly became normal practice for polyclinics to form partnerships with each other and often with hospitals that served them. These Territorial Medical Associations (TMOs from the Russian acronym), enabled streamlined administration of accounts, freeing doctors up to treat patients. They helped to prevent under-referral, albeit often at the expense of referral outside the TMO. Indeed, Sheiman (1995) reports that in Kemerovo the practice was to avoid combining polyclinics with hospitals as a deliberate attempt to counter the traditional power of hospitals. The development of TMOs allowed both organisational adaptation to local circumstances, and also the spreading of risk among a couple of polyclinics and across the primary/secondary divide. As noted above, innovation in payment systems was also made easier.

However, the New Economic Mechanism (NEM) was never effectively broadened to other regions, its implementation being merely 'on paper' (Shishkin and Rozhdestvenskaya, 1996). The planned extension coincided with the final crisis of the Soviet economic and political system. According to Twigg (1998) the NEM actually collapsed. Based on an interview with Duma health committee chairman Nikolai Gerasimenko, she claims that the collapse in state financing and the onset of rapid inflation simply bankrupted

the polyclinics in the face of demands from hospitals for payment. It is this, which necessitated alternative forms of financing – *i.e.* insurance. However this does not agree with the data I have. No respondent in St. Petersburg mentions such a catastrophe (although financing obviously worsened). Igor Sheiman, one of the architects of insurance, saw it as a development of the Petersburg and Kemerovo models (1995). Conversely, Rudol'f Galkin, the head of health care in Samara Oblast' (then called Kuibyshev, the third participating region) complains of unnecessary discontinuity between the NEM and insurance, commenting that in Kemerovo and his own region the model did indeed work well. He comments that St. Petersburg had greater difficulties having not taken account of the large population (it is not clear what he meant, nor did respondents mention this as a problem) but makes no mention of significant financial crisis either (MG 15.3.95/2).

Crucially, the ministry of health had already commissioned a group of economists to design an insurance system at the beginning of the year (cf. Kisilev, Telyukov and Sheiman, 1990) – just as the NEM model was judged enough of a success to be introduced in other regions. Indeed, insurance was not originally intended as a replacement for the whole of budget funding, but to deal with problems that the NEM was not designed to solve – the residual principle and patient rights. In that sense, it could easily have supervened upon the NEM, for which Sheiman argued. In the event it superseded it.

The introduction of compulsory health insurance

> According to the law, the introduction of compulsory medical insurance...foresaw the provision of medical help to the working population funded by a special tax...on employers deducting a certain percentage from the wage fund. The resources from contributions were considered to be an additional source of health care financing alongside non-decreasing budget funding of the sector. This would allow additional money to be directed to the pay of medical workers, and at the same time create a precedent for developing new incentive models of pay, making doctors and other personnel economically interested in working better, more and with better outcomes. In the end this would lead to the optimisation of the power and structure of the set of health care providers. Inefficient links in the structure would be cleaned out, and better, work with greater output, providing high quality medical care to the population.
>
> Natal'ya Kravchenko, head analyst, Federal Fund of Compulsory Medical Insurance, MG 30.8.96/5.

It is clear that financial instability over the short and long term made moving to a system of insurance that could ring-fence income attractive. According to Sheiman (1995) health insurance was certainly introduced as a means of stabilising health care revenues; according to Shishkin and Rozhdestvenskaya (1996) the stagnating economy certainly prompted greater support for it among health professionals. However, it was only meant to provide 30% of overall health spending, and was in reaction to longer term instability in financing

that resulted from the residual principle of Soviet Health care and various fiscal problems in the economy. This is consonant with the *universal* insistence of the interview respondents that the insurance system was originally meant to bring almost entirely *additional* finance into the system, rather than replace state finance. Furthermore, in the context of resources deficits, some complained that insurance was a "luxury" (MG 16.11.90/2), while others pointed to world experience of insurance systems being more expensive ("15%") than pure state structures. According to Kalinin, RSFSR health minister at the time, the three main benefits of health insurance were the increase in medical care output and quality, the increase in available finance and "breaking the current monopolism in health care." (MG 16.12.90/2). To re-state the argument at the end of the previous section: retrospective explanations of insurance as a "necessary" step to *replace* budget financing are misleading; it was a new idea that attempted to solve the problem of under-funding that the New Economic Mechanism did not look to solve in the first place. Furthermore, if one considers the original 1990 proposals (see below) and the 1991 law, insurance was clearly proposed in the spirit of marketisation (as opposed to the quasi-marketisation of the NEM).

The 1990 commissioned plan

The original plan commissioned by the Ministry of Health (Kisilev, Telyukov and Sheiman, 1990) was primarily seen as a means of attracting extra resources into health care – and is, as far as they are concerned therefore an innovation. It is a complex system of attracting resources from enterprise wage funds, union and local social insurance funds, trade unions, private contributions as well as from savings accruing from the economising effects of the system. It foresaw several territorial funds – possibly run by consumers themselves, or concerned enterprises, holding the insurance resources for the local health care administrators to spend on health care. The suggestion was that they might compete amongst themselves. Quality control would be realised through free choice of health care institution for the patient, with the funds exercising price control. It argued for a high level of decentralisation to the local administrative level and to the health care unit. Contributions from enterprises were to cover both the worker and his or her family, with "pensioners" (which included the non-working) covered by the local authority.

It contained four important characteristics of the law published in 1991. Firstly the notion of strong decentralisation in financing and programme-setting. Secondly it emphasises the importance of funds by-passing the ministry of health and going straight to local authorities and institutions. Thirdly it emphasised the territorial nature of the health system – that instead of the health system being divided into different sectors, these units

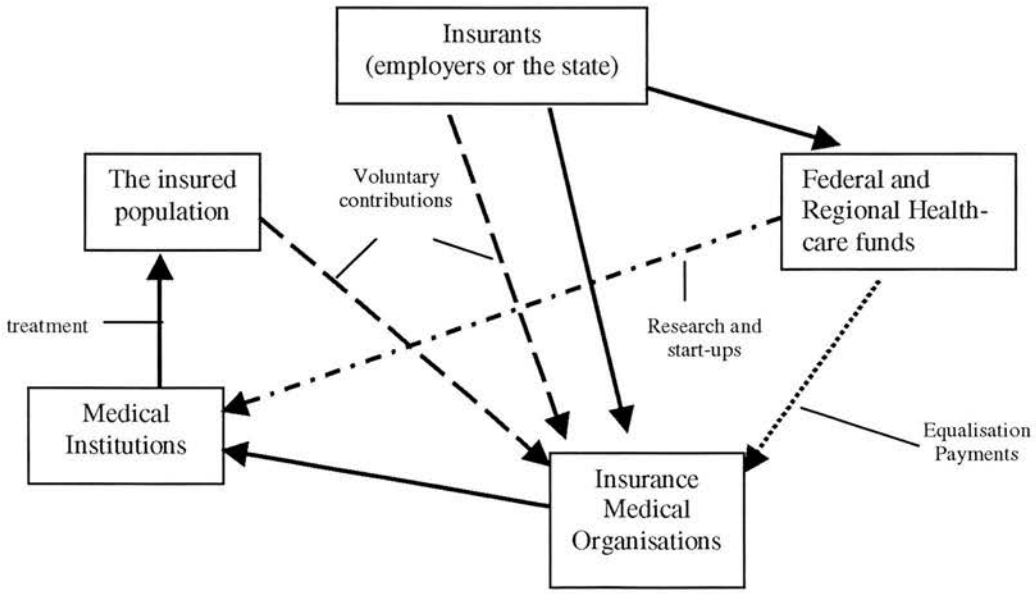
were to be organised by geographical area. Fourthly it emphasised the importance of voluntary health insurance, again as in the co-operative movement, as a source of extra funds.

However, it rapidly would have been obsolete as it stood. Although the state continued to be the majority employer for some years, already by 1991 in normative texts the word "employer" appeared rather than "enterprise" for the insurant in the system, signifying at least the psychological disaggregation of the Soviet system. Many of the proposed sources of funding ceased to exist or were in deficit – for example the trade union funds. Such changes between proposals and the 1991 law probably reflects the impact of World Bank technical advice which had begun mid-way through 1990, and the increasing self-confidence of free-marketeers within the Russian government, insofar as there are distinctive moves away from the original embedded social-corporate funding arrangements.

The 1991 law on Medical Insurance of Citizens of the Russian Federation

Approved on 28 June 1991, the law provided for the introduction of both compulsory and voluntary medical insurance. Compulsory insurance was to be paid for by employers for the working, and by local authorities for the non-working – including children, pensioners and the unemployed (see figure 5.1). It was to be enacted fully at the beginning of 1993, with some regions moving towards it earlier if they so wished. Responsibility for the system was devolved to the level of the federal subject – the oblasts, krais, autonomous republics and so forth, and the two "capitals" of Moscow and St. Petersburg.

Figure 5.1. The system as envisaged by the 1991 Law on Medical Insurance



It envisaged that every employer (or municipality) would contract with an insurance medical organisation – a non-profit making insurance organisation forbidden to take part in health care provision, paying them a percentage of their employees wages (a fixed per capita amount). The insurance medical organisation would then contract with a series of providers to provide health care for those it covered. There would be an "off-budget" (*i.e.* outwith ordinary government finances) state fund across each federal subject territory, which was responsible for certain aspects of financing: public goods such as training, research, and "equalisation of the conditions of health care provision for the population under compulsory medical insurance across the territory", with a federal fund to equalise and co-ordinate across all regions. The insurance system was designed to provide comprehensive health care to all, and would cover a territorial programme of services, which could not be less than a basic programme established by the centre. No particular rate of contribution was fixed; in draft proposals it would be set by the locality, or by insurance companies themselves within limits. Within the law there are some interesting contradictions – both citizens and their employers have free choice of insurance medical organisation, and both patient and insurer have free choice of hospital. It is not clear how all these rights were to have been exercised all at once.

Provisions for voluntary insurance were included in the same law. The intention was for insurance companies to begin offering voluntary insurance as soon as possible, so as to develop insurance practice before the start of compulsory insurance. Individuals could insure themselves, or companies could insure their workers voluntarily, in addition to the state-run system (including compulsory insurance). What voluntary insurance would be for when there already was universal provision was not clear in the text. In the interviews respondents felt it was for better hotel services (privacy, better food *etc.*), as well as access to more advanced and less invasive treatments than would be covered by the state. Interestingly, there was a general understanding of "comprehensive" as availability of cures for every condition, rather than equal access to the best available treatment.

Barr and Field assert that the 1991 insurance law as it stood was more a "rush away from the previous Soviet system than it is a well-thought-out-policy direction" (1994: 309). It is worthwhile examining the extent to which this proposed model is different to the Soviet system. First and foremost the role of the state is reduced to a regulator, a guarantor of expensive services, and an insurant of the non-working. Of course in practice many health care institutions would still be owned by the state. However this, as far as the text reads, is merely an artefact of the heritage of a state health system; great emphasis is placed on the possibility of non-state provision. It is clear that the insurance system was designed to

stimulate the private sector. There is radical devolution – the federal centre does not concern itself with health care financing to any great degree, and it is now the business of the local authorities – the federal subjects and the municipalities beneath it – to regulate. Thirdly, the role of enterprises in health care is disaggregated. Their ability to use health services as payment in kind is turned over to voluntary insurance. Fourthly there is the invention/ presumption of a new institution – the insurance medical organisation, which was permitted to undertake speculation with part of its resources in order to increase the money available to health care.

Figure 5.2. Dominant financial relationships between actors in the 1991 law

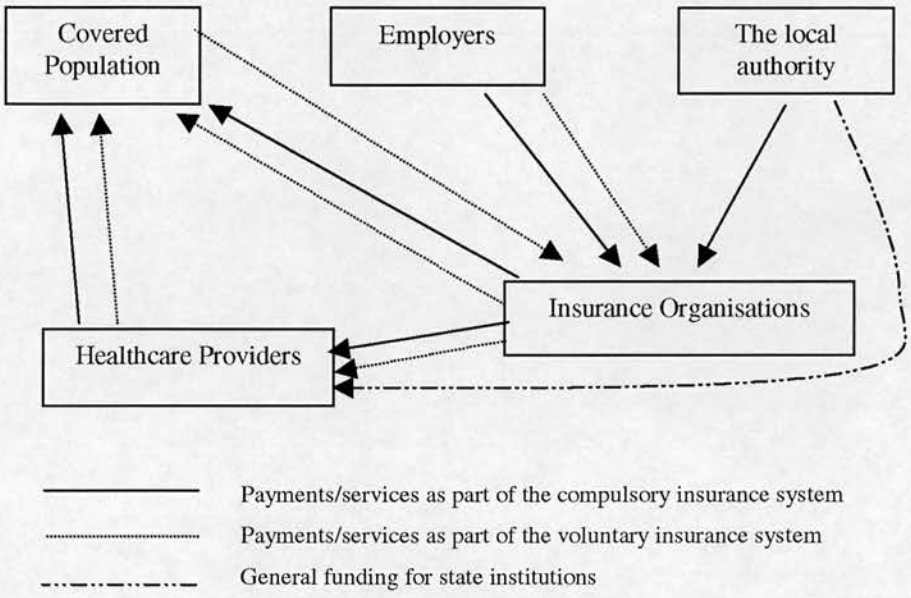


Figure 5.2 shows the extent to which the 1991 law moves the health service from being administered to being regulated, and the extent to which it is self-regulating through consumer demand, without state interference. Additionally with the use of self-regulation and the absence of state planning we see neo-liberal faith in the self-righting mechanisms of the market. No mention is made of mechanisms to avoid cream-skimming of patients either through seeking to insure healthier workforces or through varying rates. Insofar as the 1991 law proposed the broad abdication of state control in favour of a model that embodies so much consumer choice as to be contradictory, and does not consider one of the classic problems of health insurance, Barr and Field's suggestion appears justified.

The 1993 amendments

It became apparent over the next year or so that insurance medical organisations were not forming very rapidly except in Moscow and St. Petersburg, and the insurance companies in Petersburg at least appeared reluctant to involve themselves in less profitable activities such as compulsory insurance. Furthermore, criticism was indeed made of the opportunity to cream-skim the population: at a fixed contribution, insurance companies would be tempted to select healthier clients – breaking the principle of social solidarity putatively underlying the system (Sabanov 1996). Therefore in February 1993, with the implementation of the law delayed and contributions already paid frozen in central bank accounts, central government passed a series of amendments to make the law workable. Territorial funds were recast from their minimal role: they now collected contributions; they strictly equalised IMO funding using per capita norms adjusted to the profile of those they insured. They also were to oversee the operation of the IMOs.

Significantly, the territorial fund was also permitted to create "filials" [*filialy*], branches within its own region to operate as insurers where circumstances militated against full coverage solely by insurance medical organisations. In effect, the fund and its filials became the insurer of last resort. Filials are subordinate to the territorial fund itself, collecting contributions in sub-divisions of the federal region (*e.g.* the Oblast') to pass onto the fund. When acting as insurers, they will undertake their own analysis of medical practice for those they insure, as well as acting as the agent of the territorial fund in the region.

The importance of allowing the territorial funds to act as insurers should not be underplayed; it is one of the keys to the diversity of insurance funding on which this thesis is focussed. In the present analysis there are three points to be made. Firstly, allowing filials to undertake medical audit breached the independence of expert analysis from state and parastatal structures. That the funds were now responsible for co-ordinating a certain amount of investment in the health system raised the possibility of non-neutral assessment of treatment. Secondly, it also put the fund in competition with IMOs for contracts – when the fund itself was partly responsible for the oversight of medical audit and IMO activities. What should not be forgotten is that the problem over IMO operation was not simply whether or not they existed, but also whether or not they operated without breaking various laws such as the proper use of funds and the proper application of audit. In a country such as Russia which is slowly converting anti-commercial legal frameworks into liberal ones, and where many financial dealings are often semi-legal as it is, the possibility of prejudicial prosecution is clear. Thus to have the oversight body in competition with institutions it is overseeing is, of course, problematic. Thirdly, the creation of filials also compromised the notion that the

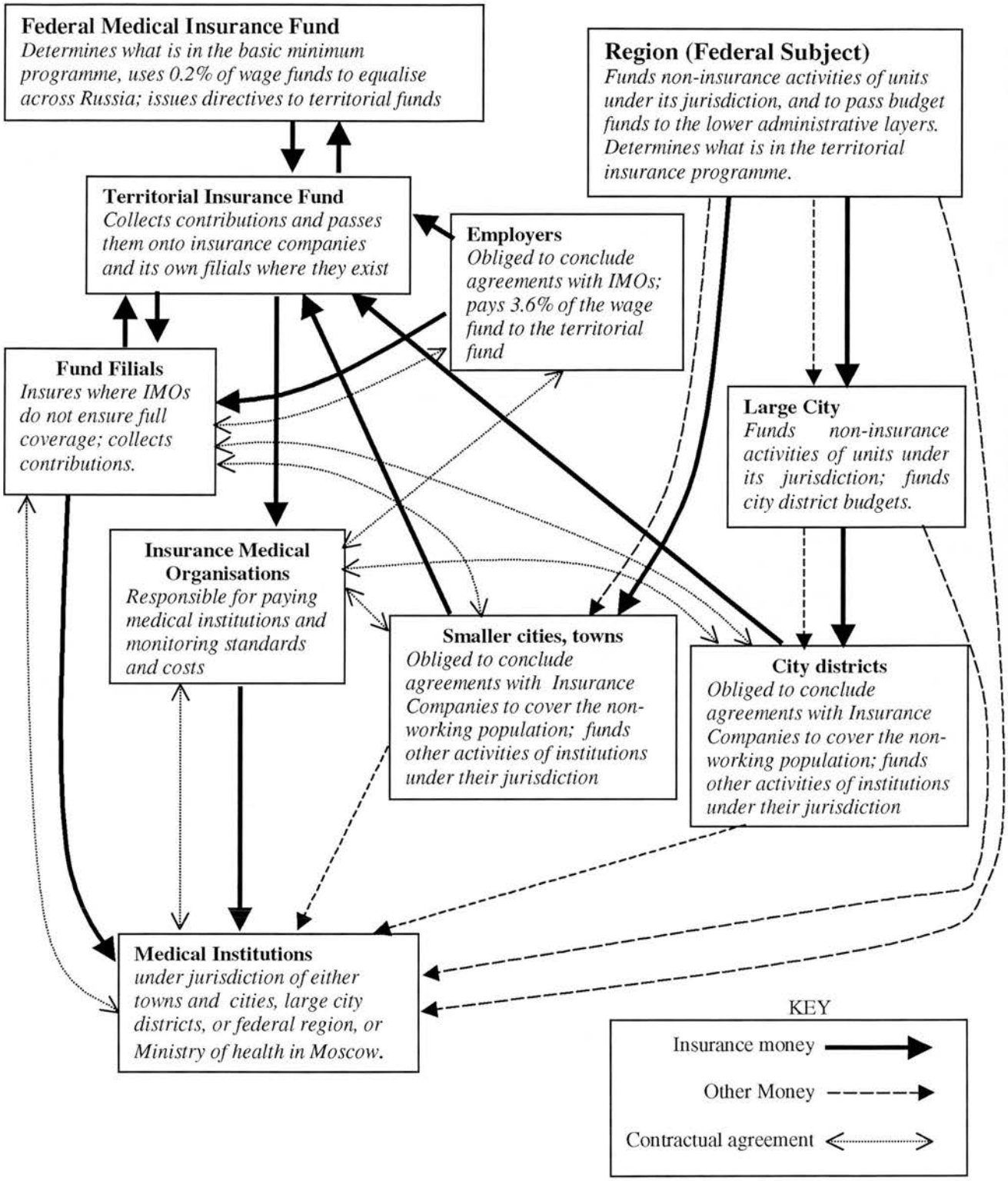
main focus of competition would, given fixed contribution rates and fixed tariffs for services, be the quality of medical audit done by different IMOs. "Market" control over medical audit was compromised. It raised the possibility in some regions of *de facto* competition between hospitals for a monopsonist purchaser.

The decentralisation of health care remained. Regions were still responsible for running their own insurance systems (the constitution approved later in 1993 only reinforced this responsibility), and the law on local self-government of 1991 had introduced decentralised control of health care institutions to the lowest level in most cases. By not treating health care units differently to other state property, this law foreclosed the proper independence of units from state (municipal) control. As seen in Chapter 3, attempts to privatise the health system from the centre were subsequently undone by the limited jurisdiction of the centre over the regions. As a result, health care units were to respond both to financial pressures from insurers, and to direction from municipal bosses. As state financing of institutions has fallen dramatically, these contrary tendencies have caused tension.

Contribution rates were set at 3.6% of the wage fund. 0.2% went to the Federal Compulsory Health Insurance Fund as part of the equalisation fund, 3.4% was to pay for insurance within the region. As might be expected, most respondents felt that this rate was far too low; in their defence it is very low by international comparison (and those comparisons were to be made with other mature systems). In effect, only one eighteenth of insurance money was to be used to equalise resources across Russia. It should be noted that as one of the social taxes it had first call on the wage fund before income and other taxes. These various contributions (pension, sick pay, health insurance) were merged in a new tax code into a Unified Social Tax in 2000 to cut bureaucratic costs, with a neutral effect on revenues to individual funds (but a subsequent higher compliance rate).

Thus the 1993 system, in its interaction with the law on local self-government, had potential for very complex structures and relationships (see figure 5.3). Through the application of control by contract rather than by direct management for a significant proportion of funding (originally 30% of funding was meant to be insurance, rising as the system developed) the vertikal' of the command economy of health care had been significantly undermined. Although the head of a health care unit was still responsible insofar as she or he was appointed by the local authority, the local health authority health care committee had little to do with the central ministry. Health care units had to negotiate (a novelty in itself) with IMOs, answer in their practices also to regional accreditation committees, and manage funds within the unit directly, within the constraints of regulatory

Figure 5.3. A generic model of a federal subject health insurance system



directives from the authority to which they were subordinate. Although in the Soviet era, there had been some networks and negotiations to obtain resources that the planned economy

had failed to organise, such activities were now broadened and institutionalised. Decisions about health care financing were made at the regional level as part of overall spending on social needs – as opposed to at the federal centre. Furthermore, specific decisions regarding the funding of municipal institutions were made at the local level. Thus most health care institutions could in principle depend upon three or four different kinds of funder – the local authority, the regional authority, the territorial fund and its filials, and IMOs.

Regional Implementation and Variation: Four models of insurance

That filials were meant to be a temporary practice until the IMO field had developed suggested that there would be different speeds of full implementation across different regions. Moreover the amendments made in 1993 occurred after several regions, motivated by the possibility of increasing funds into health care, had already begun to implement insurance ahead of time according to adjusted versions of the 1991 law (including St. Petersburg and Volgograd Oblast'). Moving from individual regional models to ones in line with federal legislation took time, and resulted in ad hoc alterations. Part of this uneven development is down to the rights and duties granted to various actors within any putative insurance system. Cities in some places developed their own semi-autonomous systems within federal subjects, complete with their own territorial fund (sometimes created in order to create a monopoly purchaser). In the words of the health minister Tsaregordtsev "Not only in every [federal] subject, but in every city or *raion* they've developed and introduced their own model of moving to CMI" (MG 14.2.96/5). Such developments were gradually standardised by the federal fund exercising its power of accreditation and threats to withhold balance funding (a good example of this is indeed Volgograd Oblast').

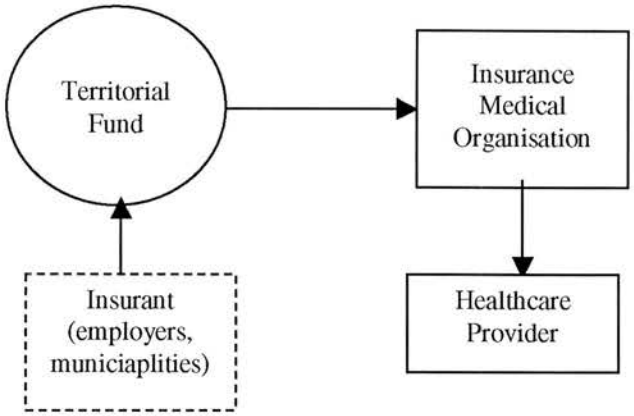
In some regions the issue of coverage was resolved other than by filials. In places such as Tartarstan, parallel systems of state-run "hospital funds" (*bol'nichnye kassy*) also served to underwrite payment that crowded out insurance companies. In St. Petersburg a city municipal insurance company was set up to operate across the territory as insurer of last resort; in Volzhskii, the second largest city in Volgograd Oblast', a municipal insurance company was and remains the sole monopoly insurer, whilst elsewhere in the same region open competition defined the insurance market.

Although by the time the interviews were taken, most respondents said there were no difficulties of which they were aware regarding the insurance of those being treated outside their own region (various agreements by that time had been concluded), there had originally been difficulties in payment across regional boundaries.

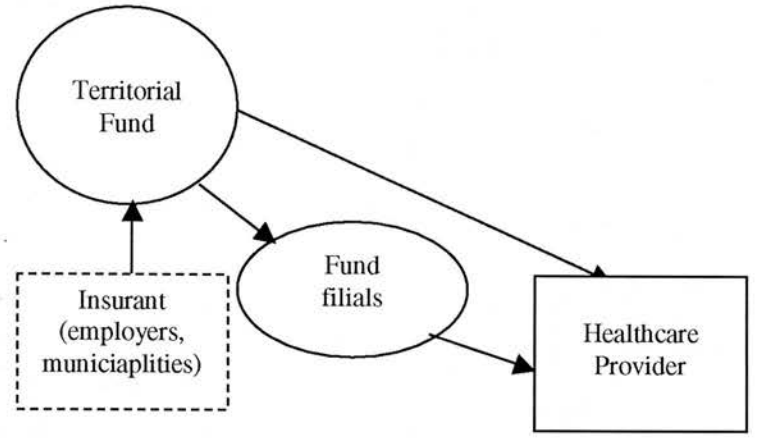
Arising out of the variety of implementation possibilities (without even considering individual implementation histories) there are four general possible models of health insurance, as identified by Kravchenko (1996, 1998) and Raison (1998) – where fund filials operate and do not, and where insurance companies operate and do not, and a few rare cases where the ostensible insurance system is used without separation of fund from filial (see figure 5.4). Kravchenko and Raison's classifications of regions of Russia according to this scheme are not identical. However, considering that Kravchenko's latest work on this matter is not only more up to date, but that she is also chief analyst of the Federal Fund we may assume her data to be more accurate. It is noted that Raison makes no reference to Kravchenko's early work with this typology – one must assume that they arrived at the same idea independently. Given the way that the presence of filials changes the mode of competition (between insurers and between providers) and the character of the system (more and less pluralistic), such a typology is highly relevant. It also testifies to the variability in health care arrangements across the whole of Russia – without even tracing individual histories of implementation. In a later chapter, and based upon the interview data, I shall seek to explore what may underpin the variable development of these insurance models. For the moment it is sufficient to explore these variations descriptively.

Model I (which Raison calls the system as defined by law, although technically all the first three are permissible) involves only or largely the insurance companies acting as insurers (at least 90% of insurance money passes through them). This does not preclude the possibility of state insurance companies operating as insurer of last resort (as in St. Petersburg) as there is no prohibition of insurance companies regarding their form of ownership. *Prima facie* one would think that the competition dynamic between insurance companies would be stronger. The control of quality and the level of service provided may also be higher as these would be the main elements of competition between insurers (price competition is not possible). There were fourteen such regions at the time Kravchenko took her data in 1996.

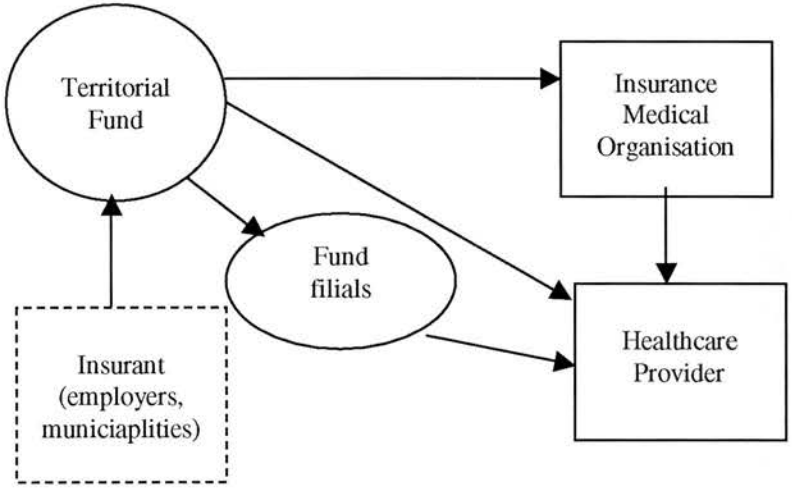
Model II involves only the fund filials acting as insurers (or at least 90% of insurance funds go through them). This implies that either insurance medical organisations have either generally failed to form, or have refused to take part in the compulsory system or have been excluded from the system either directly as a policy choice or through their non-licensing. The implication of this model is that there is no competition between insurers, although there may be, as the Volgograd Territorial Fund representative asserted in interview, greater competition between health care providers for the monopsonistic purchasing power of the fund, rather than competition for insurance contracts by IMOs.



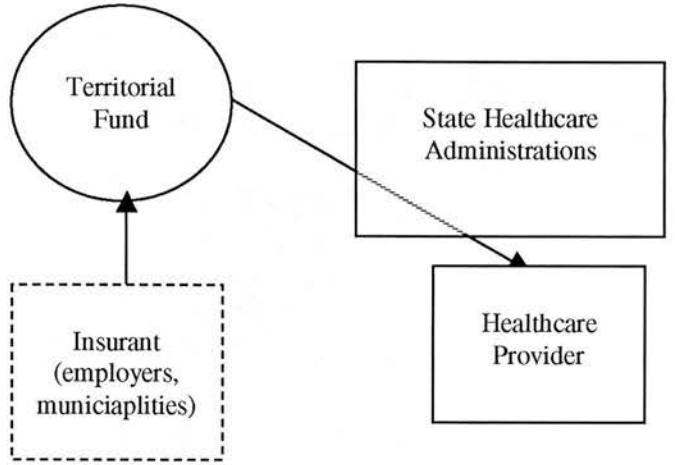
Model I
(IMO/plural model, "legislative" model)



Model II
("filial" or "fund" model, with no insurance companies)



Model III
("mixed" model – both IMOs and filials)



Model IV
(Administrative models, non-implementation of law)

Figure 5.4. Four models of healthcare financing. (From Kravchenko 1996; 1998; Raison 1998)

There were thirty-two such regions in 1996. Shishkin (1998) asserts that such a system when it was allowed in 1994 was only meant to be temporary. However, in many regions of Russia the authorities have sought to pursue an IMO-free model deliberately.

Model III is a mixed model. In these thirty-seven regions both insurance companies and filials were acting as insurers – including Volgograd Oblast'. Kravchenko argues that this dual insurer system is the result of insurance companies not wishing to work in sparsely populated peripheral regions of a territory; alternative arguments are put in chapter 9. The mix suggests uneven quality of health care across a region. There may be competition between filials and IMOs for funds. In Volgograd this appeared to lead to attempts by the fund to squeeze out the insurance medical organisations. In many regions there were calls for any doubling of function between filial and IMOs to be rationalised.

Model IV is called the "conditional" (*uslovnaya*) model by Kravchenko, which I have called the administrative model. In these six regions the fund is used as an instrument by the health care administration to reimburse hospitals, but there is no separation between fund and insurer, even organisationally. This model is a curiosity, as Kravchenko points out. Numbering six in total, most of these represent deliberate local resistance (expressed by regional leadership) to the federally determined law (Twigg, 1997). Classifying them is therefore difficult. It seems to me most useful to state that they are essentially non-competitive administrative models. While Chechnya has had its own problems, others seemed keener on obstruction rather than constructive response.

It should be noted that this focus on the institutions as a means of classifying the health systems is not the only available. As with Twaddle (1996) who stresses the wide variety of possible dimensions of classification, Kapitonenko wrote

> The outstanding characteristic in the development of CMI [Compulsory Medical Insurance] in the RF is how territories are presented with certain freedoms in the choice of methods of organising CMI, which has brought forth the appearance of a variety of different organisational models of territorial systems for CMI. They are distinguished from each other by the technology of registration of insurant and the insured, the territorial programmes [determining what treatments are covered in the compulsory system], the standards of quality demanded, the method of tariff-formation, systems of accounting and inter-accounting between CMI institutions. (1998: 15).

However, the typology used by Kravchenko is stressed here because, as this study argues, in the early years following the introduction of health insurance and local government reform, problems in governance and financial flows affect the operation of health insurance more than debates over territorial programmes, or details of payment systems.

That such variation was not the intent of the federal health ministry is evident. However what is more evident is the inertia and inactivity displayed at a time when all the regions were introducing the biggest reform to the health service since the revolution.

Corruption and inaction at the centre

> -What do you think – what causes this endless, almost yearly change of health minister? Is it a long-held Russian habit to ask – who's to blame – or is it really the case that into the ministry come professionals, unable to determine the priorities by which health care should develop?
>
> Question asked in interview of Oleg Rutkovskii, the fifth health minister in six years. (MG 20.5.98/1)

The central ministry has been marked by inactivity, corruption, frustration of reform and impermanence of top personnel. These problems extend to the period before the collapse of the Soviet Union. "The USSR ministry of health, and Burenko [minister of health] personally have displayed an irresponsible attitude toward implementing a social measure of such importance as raising public health personnel's wages," read the report from the Council of Ministers (*Pravda*, 1987). Matters did not improve much in the 1990s. After the dismissal of Vorobyov as health minister in 1992 it was said that "he never took any constructive steps to improve health care for the people...He believed that working on laws concerning health care was the parliament's job and that the executive branch had nothing to do with it, and he opposed any reforms in our medical system" (Pravda 1992b). In December 1992 Prime Minister Yegor Gaidar announced that "We have an especially large number of complaints about the Ministry of Public Health[1], which so far has not been able to present a detailed, realistic programme for reforms in the health-care system and a transition to health insurance...the problem here, apparently, is not simply the ministry's leader but the need for a radical strengthening of its entire upper echelon" (*Rossiiskaya Gazeta* 1992).

The subsequent appointment on December 23 of former military surgeon Eduard Nechaev led to speculation that he as a military man "accustomed to preferential financing, would not introduce medical insurance". This "openly corrupt" (Shapiro 1997) and "odious" (Sevodnya 1995f) minister didn't disappoint in his obstructionism, petty empire-building and malpractice. Head of the International Foundation for Protecting Mothers' and Children's Health Aleksandr Baranov, in relation to the Health Ministry's low procurement of contraceptives and the astoundingly high rates of abortion in Russia stated that "efforts to carry out the ["Children of Russia" family planning] programme have been obstructed by Russian Minister of Public Health Eduard Nechaev, of all people. It is no secret...that the

[1] The term "public health" here is the translation in the *Current Digest*; Elsewhere I have used "health minister".

minister maintains personal control over financial resources and that his incompetence and lack of understanding make things very hard" (Izvestiya 1994). He was prepared to put at risk the insulin supply to Moscow city to defend a production deal cut with a factory in Poland (*Sevodnya* 1995a), as well as being involved in the import of narcotics and the purchase of expired medicines (Sevodnya 1995f). In relation to health insurance, his own deputy (and future minister) Vladimir Starodubov later reflected that "unfortunately, from the beginning the establishment of health insurance was characterised by conflict between health care administrators and the territorial funds, which to a significant extent can be explained by the openly obstructionist policy of the previous leadership of the Health Ministry" (Starodubov and Sheiman, 1996). The length of time it took before Nechaev's eventual dismissal in November of 1995 was explained by his apparent connection by marriage (his wife was incidentally also implicated in fiddling expenses) to Deputy Prime Minister Oleg Soskovets, himself dismissed a year later for various bribery scandals and possible involvement with mafia groups.

In the middle of all this State Duma members did not cover themselves in glory. Having been handed the health care committee chairmanship the Russian Regions faction representative complained that being given "second-rate committees" to chair was "unbecoming" for such "professionals" (*Kommersant-Daily* 1996).

When Tsaregorodtsev took over as health minister following Nechaev, it is not surprising that he found matters difficult. His report on the work of the ministry in 1995 and the tasks for 1996 (MG 14.2.96) contains a number of inconsistencies. Significantly its espousal of multiple sources of finance directly contradicted the Ministry's own *Conception*, which supported unifying payment systems. His admission that the ministry had had little contact with the regions was laudably honest, and seemed to be evident in the report. However, the ministry began finally to address such matters as the need to confirm the Basic Programme in health insurance, which should have, in principle, have been the basis of insurance coverage throughout Russia since 1993. Tsaregorodtsev's general approval of the insurance system should also be noted as a change in policy. But equivocation over the direction of reform – the wisdom of letting regions determine the health system – reflected a continuing indecision on the part of the ministry.

Tsaregorodtsev lasted under a year; he was replaced by Tat'yana Dmitrieva after the 1996 Presidential election when a new cabinet was formed. She announced her intentions to increase the power of the centre at the behest of the regions. The discontinuity in personnel again held up action by the ministry. In her own words, it took three months of looking at the health system to realise that the law on local self-government was one of the key obstacles to

successful implementation of health insurance (MG 22.11.96) – a point that Tsaregorodtsev had made a year earlier. Again, in interviews, she seemed as overwhelmed as was Tsaregorodtsev with the complexity of regional variation, although not for want of trying. According to Deputy Prime-minister Oleg Sysuev,

> "Undoubtedly, both the minister and the employees of the ministry as a whole are record breakers in the government in terms of visiting the regions. This is very welcome. But often, because of the underdeveloped role of the ministry, and the absence of the governing *vertikal'*, all this in the end turns into some sort of study of the problems in each province, the examination of various very local problems, but not those of the system of interaction of such a health care *vertikal'*. (MG 27.2.98/4)

Certainly Dmitrieva's time in office was productive in this respect; under her the co-ordinating committee for the regions was set up, enabling the Federal Fund to assert its authority to normalise (as far as it could) the health systems in various regions (Volgograd was tackled in 1997). However, in distinction to her immediate predecessor she was against pluralist models of financing, suggested moving towards territorial funds being under regional budgetary control (which would have undermined the independence of health care financing – the single clearest achievement of insurance), and moving away from the "expenditure" principle that had developed in health care – which meant moving away from systems of purchasing care back towards administrative planning. This last proposal would undermine an important operating principle of insurance – that there is a connection between individual treatment and payment. That she did not appear to realise this suggests a lack of understanding of how the insurance system worked, nor of the real problems facing the regions in the face of central inertia – the need for proper regulation of insurance, and for directives upon which regional systems had, by law, to be based. Her general competence appears to have been obliquely questioned by the editor of *Meditsinskaya Gazeta* in the interview with her successor, although this has to be seen in the light of her poor relationship with the media over the period of her office. The appointment of her successor, Oleg Rutkovskii, was greeted in Meditsinskaya Gazeta with "he should be an improvement, as it couldn't get any worse" (MG 20.5.98/1). It was only appropriate, given the oscillations between previous ministers, that on arrival in the ministry Rutkovskii, a previous employee of the ministry half a decade before, appointed a pro-insurance economist as deputy, and espoused, as did Tsaregorodtsev, the pluralising of health care finance. Rutkovskii himself spent his first three months assessing the situation inside the ministry, which he found "as bad as always", visiting only four regions (Dmitrieva averaged nearly three a month). He found that "multi-lateral agreements" (*i.e.* piecemeal) were one of the ways that the regionally fragmented situation in health care could be improved (MG 21.8.98/1: in other words, to carry on as before without developing overall strategies.

Events then began to overtake the health ministry, with the overall changes in government that followed. Following the collapse of the Kirienko government in the wake of the financial crash of August 1998 Vladimir Starodubov, who at least had been deputy health minister for a number of years, and was the author of several thoughtful articles on the problems in the insurance system, replaced Rutkovskii. Unfortunately, the conflict between Prime minister Primakov, who had been forced on Yel'tsin by the Duma, and the President came to a head in June the following year; in July 1999 Starodubov was succeeded by Yurii Shevchenko, previously head of the St. Petersburg Military Medical Academy. Shevchenko's term (he is still in office at the time of submission – May 2002) is possibly most remarkable therefore for its longevity. He himself has become a strong advocate of expanding pay medicine, arguing that "free" medicine was "the greatest swindle of the twentieth century, dreamt up by romantics" (*Vremya Novostei* 2002), and that plural sources of financing was the key to raising quality and resources.

Alongside the corruption, inactivity and indecision in the health ministry there was also a great deal of conflict between ministries over health care. Much of this conflict was with the Ministry of Finance, who sought both to liberalise the system and to get access to insurance money. As examined in the last chapter, the Ministry attempted during 1994 to intervene to privatise parts of the health system. This was continually frustrated by parliament and the absence of a proper law on privatisation of state property. Rather incoherent plans to individualise health insurance (allowing citizens to contract with whoever they want and allowing them to use contributions to pay for health directly thereby encouraging – in theory – private practice) were similarly blocked a year later (Sevodnya 1995b). The independence of the health care financing system also came under attack almost from its inception. Following early attempts to find loopholes in the original law allowing the budget appropriation of insurance contributions (*e.g.* MG 19.2.93/2), over a number of years the Finance Ministry sought by other means to "consolidate" the federal insurance funds – pensions, accident/sick pay ("Social Insurance"), health and unemployment – into the state budget. This would have made them susceptible to budget raids; as it was the pension fund was owed billions (new denomination: millions) of roubles by the state in unpaid contributions. Again, the State Duma, supported by the health ministry, frustrated these attempts, arguing that the principle of dual executive-legislature control as determined by law must remain. (Kommersant-daily 1995; Sevodnya 1995e; MG 24.7.98/3). The finance ministry itself was causing problems for the governability of the health system; its accounting procedures put no kind of conditionality on the money that it passed on to the regions. Therefore whatever money the health ministry attempted to get out of central fund

for the system had no guarantee of being put into health care. This not only undermined attempts at direct reform, it also made a nonsense of efforts to equalise health expenditure across the country.

The lack of "joined-up" government resulted in several anomalies. There was the law on self-government, which undermined the ability of the regions to control their subdivisions, and laws on state and municipal property that removed indirect levers of management. The commercialisation of medical practice also ran foul of constitutional guarantees and attempts to defend a free health service. This frustrated the attempts to the general procurator to prosecute institutions for charging for services guaranteed to be free under the constitution (*Kommersant-Daily* 1996).

Some of the confusion and conflict infected journalists, no doubt coping with contradictory sources between and within the health and finance ministries. According to one senior researcher in Moscow writing in 1992, the rate of contributions was set to vary from 7% to 8% (and indeed did so in Volgograd), that large parts of the health service were to be moved to the fee-paying sector (*Izvestiya* 1992a). Another report stated that insurance had been put on hold while Nechaev was in office; it wasn't. One stated baldly that insurance covers 29 different medical specialties; not only had the base programme not been set by the ministry at that point, the concrete decision about what is covered is a matter for each region. Moscow based journalists, in common with many Western observers and agencies, in general over-estimated the importance of voluntary insurance – outside Moscow it was negligible in its impact on health care resources.

Overall, the lack of guidance from the centre that interview respondents complained of was not only the result of structural alterations, although those were serious. It was also due to ineffective, obstructionist and (in the first half of the decade) corrupt regimes and instability of personnel in the central ministry, and time-consuming conflict between the health and finance ministries that made for weak control over an ever-diversifying set of regional health systems. In the words of the head of the Siberian Medical Association, formed over the territory of Siberia to provide the co-ordination that the central ministry was not):

> Unfortunately, in recent years [inter-relations between the regions and the centre] have been almost destroyed. In our view, it is one of the reasons for the relative ineffectiveness of the reforms. In particular, the passing of the law on state and municipal property finally destroyed the vertical branch of governance, and the Ministry of Health was not oriented in time to events. Therefore there has come to pass a paradoxical situation: The Ministry of Health works by itself, not always keeping up with the situation in the localities, and the territories, having got used to working under the leadership of the centre, have begun to search for new forms of governance, that would allow them to survive in conditions of reforms that have already begun. (MG 1.4.98/4).

In considering the implementation of the models in the two research sites (to which we turn next), we examine just two of the 83 regional models. In both regions actions on the part of agencies (in St. Petersburg the City government, in Volgograd the Territorial Fund) have led to further nuancing of the process of reform. While St. Petersburg in pursuing the legislative, IMO model, amended (officially only "temporarily") the nature of competition in order to make it sustainable, Volgograd Oblast' experienced both rapid growth and disorder. The re-establishment of governance led it to an uneasy "mixed" model there, which, in the context of financial crisis, appears distinctly unstable.

Implementation in St. Petersburg

St. Petersburg, the former capital of the Russian empire, was founded in 1703 by Peter the Great on marshland captured from Sweden. He intended it to be his "window on Europe", establishing his capital there as part of his attempts to re-orient Russia westwards towards what he felt were more civilised and advanced countries. The city is an architectural treasure, a network of canals and palaces dominating the city centre. Although deprived of its capital status in 1918 when Moscow was restored to that position, it continued to have great importance as a cultural and industrial centre, and retained a strong sense of identity and "difference". A wave of urbanisation in the 1960s pushed the population up to around 6 million. Renamed Leningrad in 1924, the population voted in 1991 to change its name back to the original. President Putin along with other Petersburgers in the Kremlin has conspired through the location of international summits and other devices, to reassert the authority of Petersburg as the "second capital". The surrounding area, a separate federal subject, is still called Leningrad Oblast'.

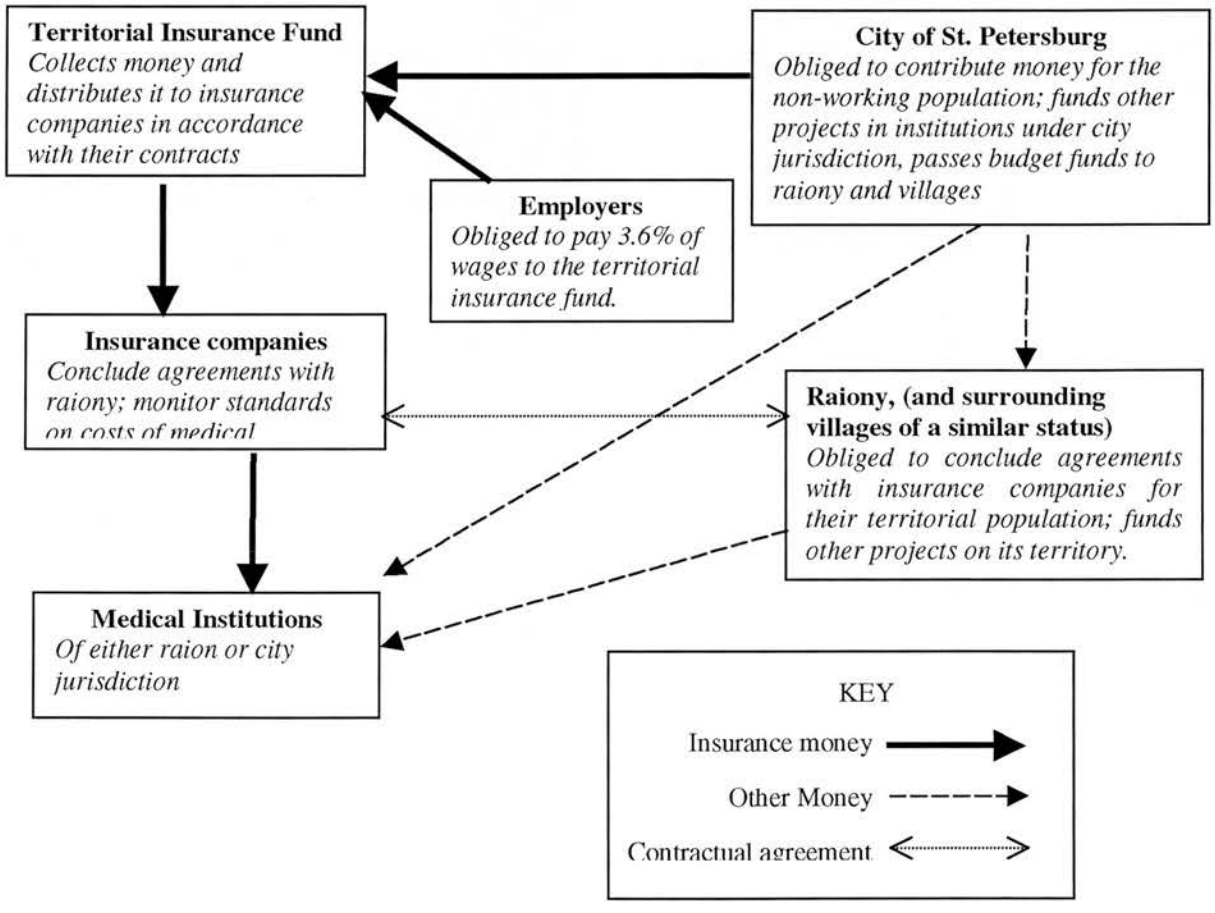
The city itself is made up of municipal *raiony*, ("regions"), and outlying towns and villages of similar status. All of these entities are subordinate in the same way to the city council. Having previously been governed by the outspoken liberal Anatoly Sobchak, who was voted out under a cloud of corruption allegations, it is currently governed by the former deputy mayor (construction) Vladimir Yakovlev.

St. Petersburg, under the leadership of the newly appointed head of health care Valerii Koryukin in 1993 introduced health insurance at variance with the model proposed by Moscow. Under the rubric "Temporary regulations", in November 1993 issued by the mayoralty, it introduced what was known as the "territorial principle" of insurance. Instead of allowing companies to conclude agreements with insurance companies for their workers, *all* residents of a municipality were insured by that municipality, with 3.6% still being levied from enterprise wage funds, and contributions for the non-working coming from

municipalities (See figure 5.5). This "territorial" method of financing was opposed to the "productive-territorial principle" embodied in the federal law where employers are the insurants for their workforce alone. This defended the integrity of local funding, as only one or two IMOs would operate in each *raion*, and under contract only to the *raion* administration. Koryukin defended the move as a simplification:

> The imperfections of the law are clear. Today it is clear that we could not introduce the productive principle. This would be technically extremely complex to have, let us say, computer accounts for all the insured. There are five million here! Moreover, according to the productive principle everyone has the right to choose his own insurer, doctor and so forth. And this all the while that neither doctors, nor insurance companies have experience of working within the compulsory insurance system. (MG 14.6.95/3)

Figure 5.5. Organisation of health insurance financing, St. Petersburg



In effect, St. Petersburg pre-emptively moved to counter problems in governance that insurance threatened to create. Within each *raion* there would be only one or two IMOs

operating, and by contract with the *raion* authorities. Planning functions were preserved more effectively, without losing competition between IMOs for municipal contracts. The territorial fund remained a relatively small organisation that insured nobody, but sought to co-ordinate insurance activity across the city (see chapter 8).

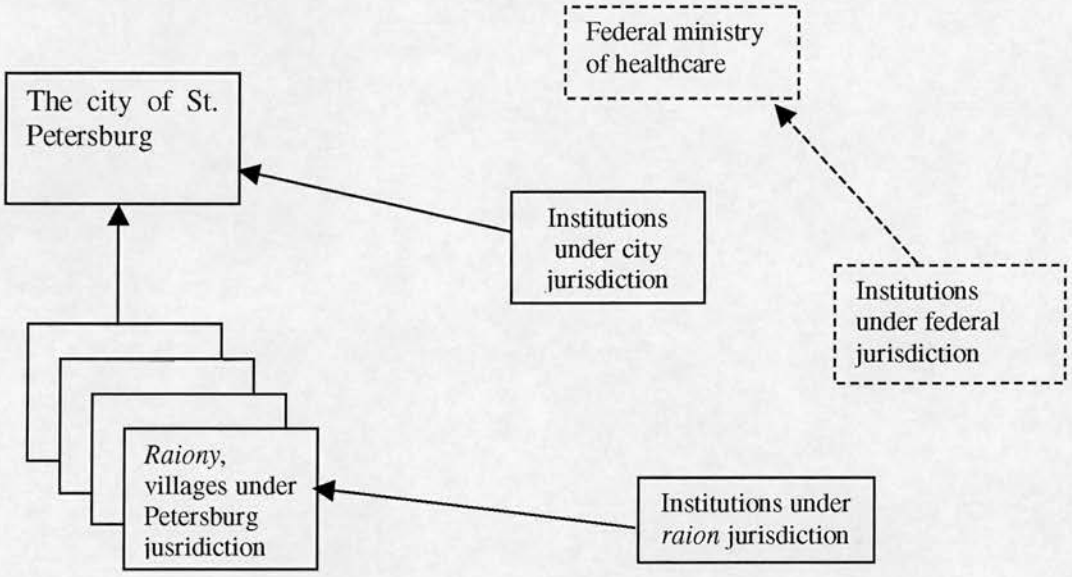
In the context of the failing economy in the 1990s, operating by this system implied that companies, able (indeed obliged) to pay their share, were also subsidising the health care treatment of the non-working, whose insurant, the state, could not raise the finances to fulfil its insurance obligations in full. According to some respondents in St. Petersburg this had caused some disquiet amongst larger industrial concerns, annoyed that their workers were getting poorer health care than they were paying for. In 1995 a group of industrialists formally complained to the territorial fund and the city authorities. However, according to the *Meditsinskaya Gazeta* report (and supported by interview data), the experience of Leningrad Oblast' around the city in operating the productive principle had led to near collapse through sheer complexity (MG 28.7.95/2). Pressure from the Federal Fund has also continued. In 2000 (a year after the fieldwork for this study) the Governor[2] suspended part of the temporary regulations, allowing companies (but not obliging them) to conclude separate agreements with insurance companies. Take-up has subsequently been very slow, with both enterprises, unable to alter the funding arrangements (moreover the Unified Social Tax had already been introduced) understandably unwilling to burden themselves with extra paperwork, and the large insurance companies unwilling to complicate their own insurance arrangements. In effect, the territorial principle still dominates (Meditsina Peterburga 2000).

The system also benefits from clear political lines of authority, making the governance of the system clearer (figure 5.6). Apart from federal institutions, ultimate executive authority over both the insurants and the medical institutions rests with the city – the authority that is also responsible for co-ordinating the healthcare system. As we shall see in later analysis, the interaction between the political structures and the finance structures gives an advantage to St. Petersburg (and Moscow City) that Volgograd Oblast' and other regions simply do not have.

The interview data suggests that clearer lines of accountability in local government and the rejection of the "productive principle" of insurance have been key to the relative success of insurance in St. Petersburg.

[2] The title of the elected head of the St. Petersburg federal subject changed in 1997 from mayor to governor.

Figure 5.6. Organisation of political authority in health care, St. Petersburg (→ indicates upward lines of accountability).



Implementation in Volgograd Oblast'

Volgograd Oblast' lies across the Volga on the border with Kazakhstan just North of the Caucasus. It consists of the large administrative centre Volgograd, originally a trading post and fortress called "Tsaritsyn" for the expanding post-Tartar Russian empire in the Southern half-desert Steppes, positioned at the closest point between the Don and Volga rivers. Most famous in its incarnation as Stalingrad (1925-1961), the city is home to a million of the Oblast's 2.7 million population and runs along the banks of the Volga for around 50km. It is a highly industrial city, with few particular cultural treasures or traditions. The surrounding Oblast' is itself dominated by agriculture; the next biggest town is nearby Volzhskii, with a population of 400,000, built in the late 1940s to house the workers on the hydroelectric dam across the Volga that provides much of the energy for the two cities. The other cities are all below 100,000.

Although Volgograd was not involved in the New Economic Mechanism experiment, it was one of the first Russian regions to implement health insurance, in the middle of 1992. However, as the federal law was under review and much of the detail had yet to be finalised, the system chosen differed importantly from the finalised federal version.

There was of course, no territorial fund. Insurance companies could vary contribution rates according to the risks associated with any particular enterprise within limits and depending on the class of the employer. Rates could vary between 5.5 and 8% of the wage fund (Sabanov 1996). Thus contributions were higher, and were more flexible than the 1993 provisions allowed.

Following the introduction of the law in 1993, the territorial fund was created, which sought to bring order by registering various insurants (employers *etc.*). At first the system was apparently operating so well that the Federal Fund was holding workshops in the Oblast' for other regions. However, there was soon resistance: with continuing economic decline money became tighter. Municipalities and small towns resented handing over equitable pan-regional per capita funding. Exploiting the lack of central legislation, many of these towns and areas formed their own filials independent of the territorial fund as a means of holding onto their own money (figure 5.7). Social solidarity was effectively abandoned, as rich regions ceased to share their wealth. At one point, according to the deputy director of the territorial fund, there were 44 fund filials, many operating entirely outwith the control of the territorial fund, and many taking advantage to embezzle money. The reluctance to deal with the central fund was, according to the deputy director in 1999, due in part to an impression that "the territorial fund was some sort of bag of money, on which sat someone nasty – the executive director. He could put his hand in the bag and give money, or indeed not give it".

The breakdown in financing having inherited a more generous insurance system quickly led to severe indebtedness on the part of the insurance companies towards health care institutions. In Volzhskii the city authorities tried to ban the operation of the Oblast' territorial fund (MG 12.11.97/4), whose filials there, in Volgograd and in the third largest town Kamyshin were, as far as the Territorial Fund was concerned, "principalities" not subject to central fund control. The agricultural area filials refused to hand over money for the non-working (MG 24.12.97/4).

Central to the problem of organising the insurance system was the inability of the Oblast' authorities to control the activities of the lower-level local government units (see figure 5.8). Under the law on local self government, they were able to dispose of municipal property largely as they wished within the Oblast', which included in many circumstances, resources for health care (*e.g.* cf. MG 24.12.97/4). Although there were some legislative powers available to the Oblast' authorities, the legislature was typically slow to take decisions, many of which were unenforceable. Unlike St. Petersburg, there are no important Federal Ministry health care institutions in Volgograd.

Figure 5.7 Volgograd Medical insurance 1993 – 1997.

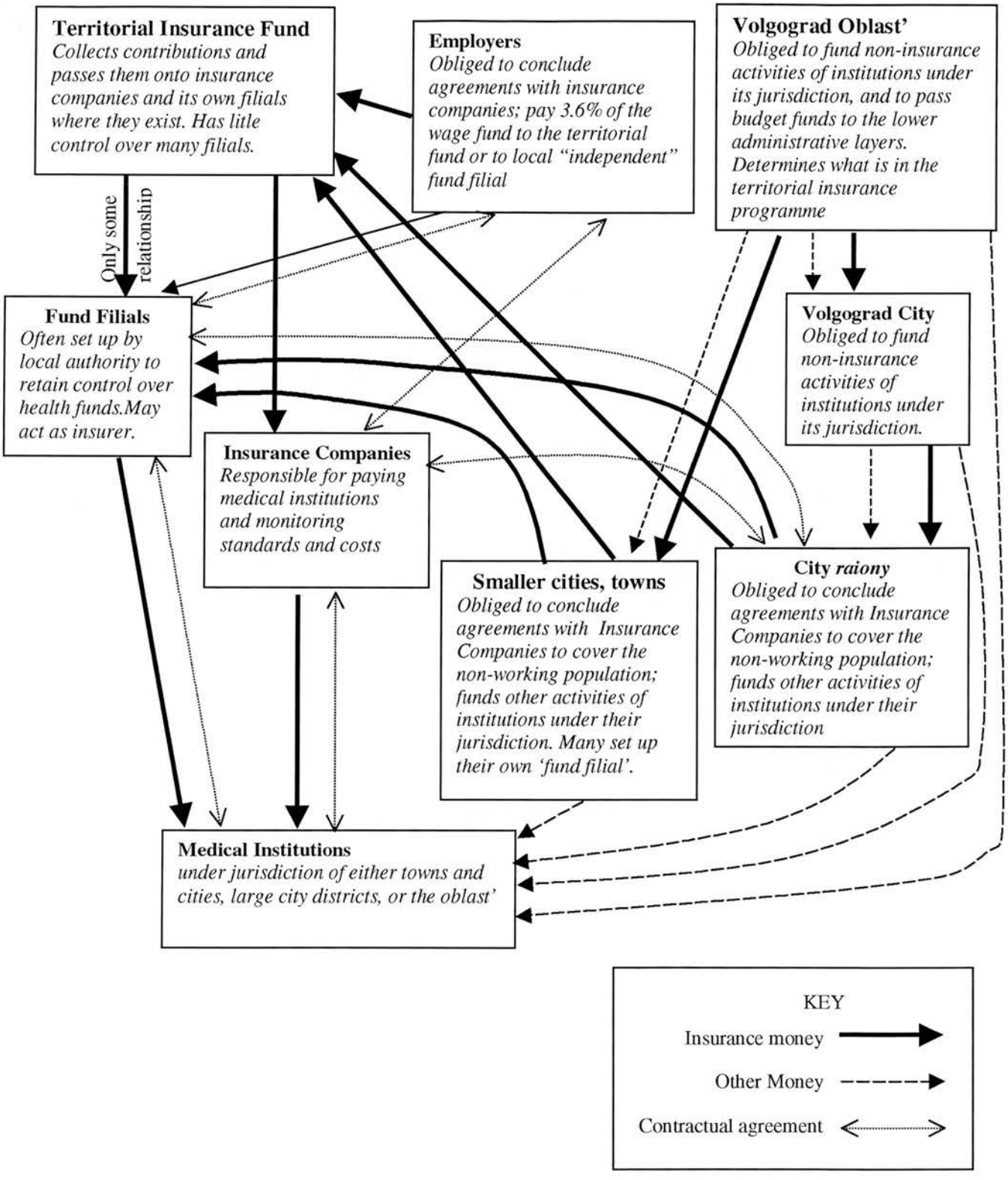
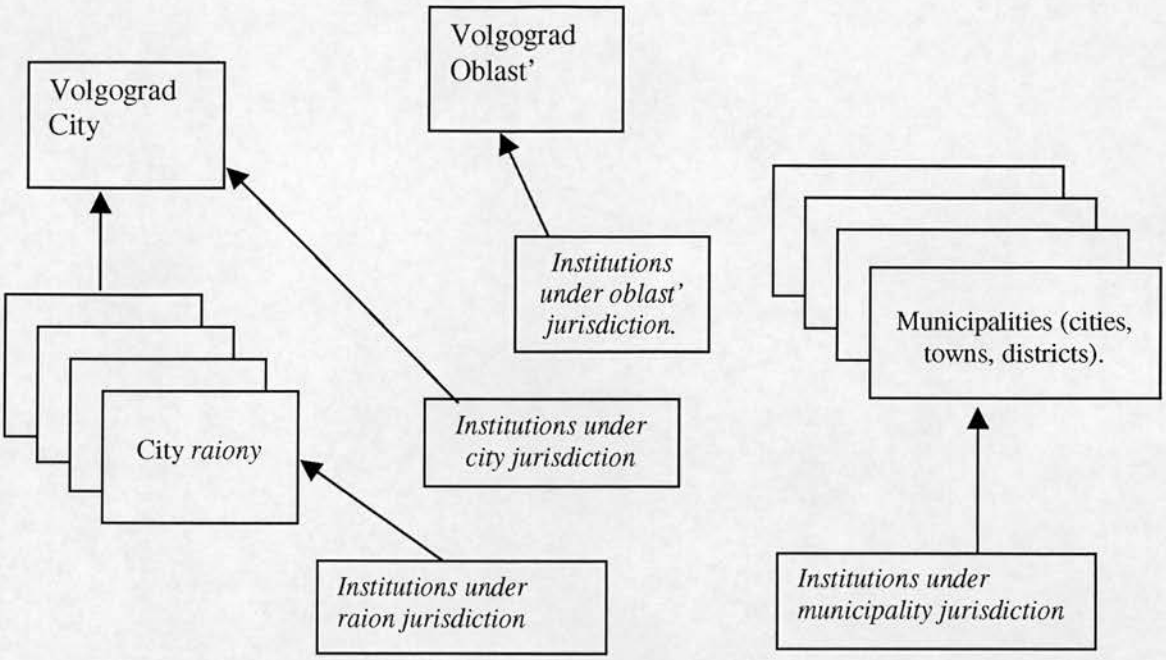


Figure 5.8 Organisation of political authority in health care, Volgograd Oblast' (→ indicates upward lines of accountability).



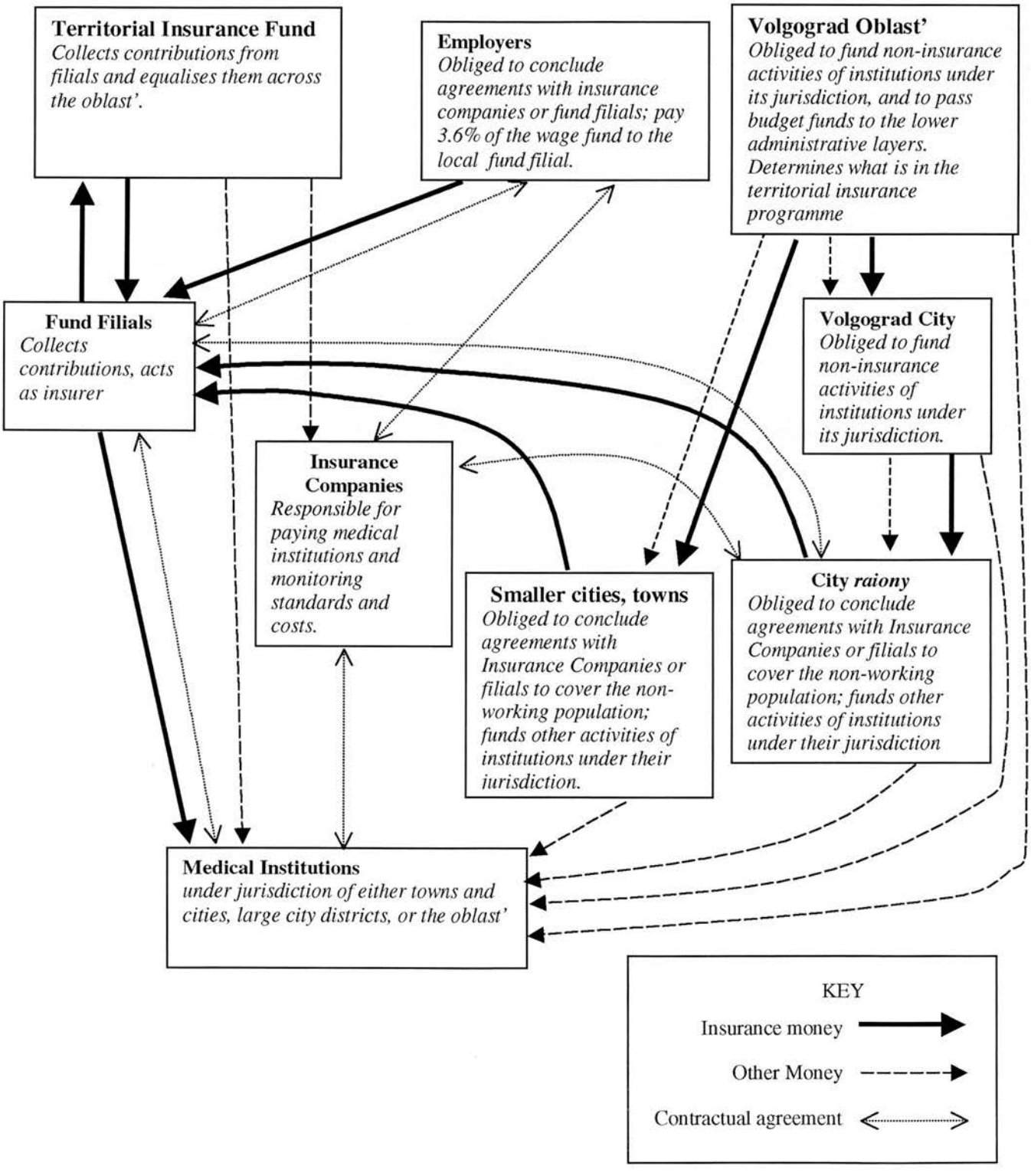
As examined in the next chapter, local government structures in the Oblast' also meant that the Oblast', the authority responsible for setting standards (including the territorial programme and other priorities) was only marginally involved with enacting them (most health care institutions are run by lower levels of government). Lower levels of government complained that the Oblast' would move between inertia and the setting of unachievable targets. Disparities between the two rich cities and the rest of the region worsened relationships between governmental strata.

It was only with the re-establishment of a single system of vertical control with a new fund board and the forcible closure of the filials that the Volgograd system was able to stabilise. However, by this time receipts were falling faster; insurance companies were disappearing from a high watermark of 32 declining by five or ten annually – through bankruptcy, loss of licence for malpractice and so on – down to 13 at the time of interview with the deputy director of the territorial fund in February 1999. For about a year and a half, the Oblast' followed the model as laid out in figure5.3 – where the filials are safely under the jurisdiction of the territorial fund.

However, the criticism patently circulating amongst the health-care community was that there was a doubling of functions (see chapter 8) between the territorial fund and its filials, and the insurance companies. Combined with the financial crisis that struck Russia in

August 1998 and a common feeling that the system still lacked clear governance, the territorial fund moved to eliminate the insurance companies from handling money to be paid to health care providers, allowing them expenses only in order to carry out their monitoring

Figure 5.9 *Volgograd Oblast' Health Insurance 1999 -*



and quality control function. This inevitably left them without incentives; it was also, in the opinion of other respondents, actually against the federal law. Effectively Volgograd had moved, according to Kravchenko's typology, from the mixed to the filial model. It now operates along the lines of the model shown in figure 5.9.

What figure 5.9 may not capture fully is the extent to which insurance money is now almost entirely within the control of the territorial fund. The ability of the Oblast' and the city authorities to raise revenues is pitiful; a large number of prescribed public health measures are now being paid for by the fund, as indicated in the diagram.

What this appears to represent is the resolution of instability in the Volgograd system. The region's ability to govern is compromised by laws on municipal ownership, weak financing and poor relationships with lower levels of government. The ability of the fund to co-ordinate and exercise control through financial authority places it in a stronger position to exert greater influence over the development of health financing. This is in contrast to St. Petersburg where the coincidence of power structures and financial capability, allied with an interdependence between the fund and the insurance companies, makes a far more stable system. This is an argument – much simplified here – that I will pursue in the following chapters.

In this chapter I have sought briefly to review the various reforms of the Soviet and then Russian health care systems from the late 1980s onwards. I have sought to show how these reforms have varied dramatically across Russia, and to set out in some detail the implementation in the two research sites.

What appears most striking is the discontinuity not between old and new systems, but between the criticisms made of Soviet Health care during *glasnost'* and the ultimate solution of insurance. Insurance in and of itself provides incentives on the part of health care institutions not to offer bad treatment. It can also act as a means of exerting financial pressure on institutions to reform and innovate practices - but not when prices are fixed, and insurers are obliged to pay unless bureaucratically determined norms are not followed. The main tasks facing Russian health care – the prioritisation of primary care and general practice as opposed to hospitalisation, the rationalisation of excess capacity and the public health crisis – need to be faced collectively over a given territory. The Russian law on insurance encourages the fragmentation of demand for health care. It also is in contradiction with the law on local self-government, undermining system governance. Regions have had to evolve devices to co-ordinate and innovate within health care – either through the territorial fund, which is now the dominant subject in most territories, or through strengthening the

territorial power of the local state, as in Petersburg or as happened in Moscow Oblast' with consolidation of health authorities.

It is in this sense that the story of health insurance in the regions is how they try to resolve the problems that the central government has set for them.

Part II – views of the respondents on the operation of the system

In this second half of the thesis, I explore in greater detail the operation of the health system. In chapters 6-8 I consider the views and concerns of three different sets of actors – those involved in managing the health system at local and regional level, representatives of those working in health care (the medical workers' trade unions and the new medical associations), and representatives from the territorial funds and the insurance medical organisations. In chapter 9 I attempt briefly to examine whether broad trends within these two sites might be generalised to the rest of Russia.

6. The Administrators

I interviewed several health care committee heads from the lowest level of administration in both cities. In St. Petersburg this took in 9 of the 19 municipalities, and 5 of the 8 Volgograd city heads as well as the head of health care in the second largest town in the Oblast', Volzhskii. It is this level of administration that is responsible for contracting with insurance companies or fund filials to insure the non-working within the municipality. Under the law on local self-government it is this level of government to which the vast majority of medical institutions are subordinate. Therefore it is directly connected to both the organisational and financial innovations of the past ten years. Each municipality can vary in size, from under 100,000 in the outlying areas of St. Petersburg, such as Petrodvorets, to nearly half a million in Kalininskii *raion*. In Volgograd a city of a million people is divided more or less evenly in terms of population across the municipalities. Volzhskii, 30km from Volgograd, has a population of 400,000. Material in this chapter is also drawn from interviews with representatives of the health care committees of St. Petersburg, Volgograd City (Social Policy committee) and Volgograd Oblast'.

All the municipal administrators had been medically trained, and all, as a requirement, had formally studied healthcare management. In St. Petersburg three of the respondents were paediatricians; the third I encountered noted that there were many of them involved in health care management and reflected that they might possibly be more optimistic and therefore prepared to take on healthcare management! Although Shishkin (1995) suggests that conservatism in health care reform has been generated by a certain number of personnel transferring from the military health service (in actual fact this appears to be a pop at the ex-surgeon-colonel Eduard Nechaev, health minister during the initial

implementation of health insurance), only one respondent had done so (the health care head in Petrodvorets, St. Petersburg), although he certainly fitted Shishkin's conservative paradigm. All the rest had come from the civilian service, and most had worked in their municipality, or close to it, for most of their working lives. They had all been appointed to health care management in some capacity before the collapse of the Soviet Union. All had been head doctors of at least one institution beforehand. Methodologically, it was notable that the sharpest criticisms of the current system and of the state of civil health care was the incomer from the military service, the head of Petrodvorets health care, who testified to the sorts of problems – bribery, queuing, perverse referral practices, that are common currency in newspapers, which others shied away from.

In Russia, the health system since Soviet times has always been managed by medical professionals – from managers of hospitals (head doctors) right up to the Minister for Health. The health administrators interviewed expressed resistance to the innovation of managers who were not practitioners first (although healthcare management was being offered as a training option to non-medical personnel in higher education institutions in both sites. This may be seen as part of the general defensiveness and plea for understanding expressed since the days of *glasnost'*. In the first round of St. Petersburg interviews in the period before the elections to the city Duma, four of these municipal administrators expressed a desire for there to be more doctors representing them.

However, given that the service has always been run by doctors, calls for consideration are perhaps misplaced. Unlike services in the West where the medical profession dominates in system organisation, in Russia cost-containment has never been an issue. This is of course partly because of implicit budget limits in national health services. But it is also arguable that the management of doctors by doctors in a planned economy of health care reinforced cost containment over good medical practice. The professional seniority of doctors in management positions permitted their insistence on certain clinical practices and, for want of a better word, production targets. Practitioners are in a position of academic inferiority to their managers, as well as beholden to them for promotion. In effect, the use of doctors in management diminishes the defence of "professional practice" against managerial decisions. Thus the imposition of simplistic quality controls such as time spent in one's surgery, beds visited *etc.* could be enforced by a superior reputation and set of qualifications (as well as other parts of the Soviet apparatus) without disputes focussing on actual medical outcome and practice. Indeed in the previous chapter it was reported that some of the lack of prestige felt by those medical professionals working in the system was in part due to superiors not respecting them enough; such systems of management are

undoubtedly a source of this. Studies of the experience of the introduction of clinical directors in the British NHS use of doctors in management shows that being part of management began to threaten the "collegiality" between directors and fellow staff (Thorne 1997). The more permanent use of doctors in management blurs the distinction between management and profession, contributing to the poor level of professional organisation within the health services. Although the municipal administrators identified themselves proudly as doctors, it is only to be expected that the clash of roles found in those becoming clinical directors in the UK – between clinician and manager (Willcocks 1994) – in Russia can only be resolved by becoming a manager. In turn, the main health care apparatus right up to the minister is similarly dominated by qualified medical professionals, reinforcing both hierarchy and the paradoxical sense that the concerns of medical staff are not listened to. In early 1990s debates around formation of a trade union strictly for medical staff, a common insistence was that they include practising doctors only, excluding managers (see next chapter). It seems valid to make a distinction (which respondents did not make) between doctors as management and doctors as practising staff.

The chief organisational difference between the Petersburg and Volgograd Oblast' respondents is that in St. Petersburg the municipalities are not independent of the federal subject, that is, the city of St. Petersburg. In Volgograd Oblast' the city municipalities are subordinate to the city, which itself is quasi-autonomous from the Oblast'. Volzhskii is in a similar situation, but is not divided into municipalities thus empowered. In the Oblast', therefore, there is a more complex system of governance that can result in three levels of sub-federal state ownership and therefore control – oblast', city and municipal. In St. Petersburg there are, accordingly, only two.

The respondents were invited specifically to talk about the structure of decision making in health care, the influence of politicians over the development of health policy, and the influence of other actors, as well as reflect upon the nature of the insurance system as they experience it. In St. Petersburg, additionally, they were asked to reflect upon the experiences of working within a city which has had a tradition of innovation in health care, especially within the last ten to fifteen years.

As with all respondents, interviews ranged over a wide area in response to any one question (indeed, some could talk for half an hour in response to only one question!). I discuss here the issues that seemed most important to them with regard to the new organisation of health care.

Finances

It seems appropriate to begin with the subject that dominated all the interviews with all respondents in this study: money, and the lack of it. As Soviet healthcare had historically been financed by the 'residual principle', expenditure on health has remained very low, worsening after the end of the Soviet Union and the collapse in state revenues. Although it could come cheaply because of the inheritance of low pay and cheap Soviet pharmaceuticals, the cuts in health care finance combined with inflation have meant that across large parts of the Russian Federation there is not only little or no money for pay, medicines and food, but many hospitals are kept heated and lit by diktat of the authorities in the face of severe indebtedness to the energy companies (and in some cases the lights have indeed gone out). Capital repairs and investment in technology have to be discounted almost universally. Although the interviews were taken over the seven months after the crash of the rouble in August 1998, financing problems had existed before then; the crash itself in hindsight did not have the severe impact that was expected. In a 1995 survey, 69% of regional health care heads surveyed felt that "absence of adequate funding" was the greatest problem in the introduction of health insurance (MG 31.3.95/4).

That the contribution level should be higher was generally agreed among those who spoke about it, and there have been constant proposals at the centre to raise the level of contributions across Russia. However, as the head of Kalininskii *raion* in St. Petersburg remarked, it would be a major step forward simply to have the financing they were due in the first place.

St. Petersburg and Volgograd Oblast' are not the worst financed regions in Russia; St. Petersburg year on year raises about 70-80% of insurance financing norms. In Volgograd the figure is about 50% overall. Expenditure is broken down into articles. Various federal subjects will prioritise these differently. In both the research sites the top three articles were pay, food and medicines, in that order. In Volgograd, therefore, often there was only enough money to pay the doctors, but not for anything else. Thus even in these two subjects who have better financing rates than other areas, the lack of financing, according to the administrators, undermines the new system:

> We've had to return to the pre-1988 redistributive system. This is the paradox, the tragedy of our national health system and in particular in St. Petersburg, our market relations have disappeared.
>
> Head of Vasiliostrovksii *raion*, St. Petersburg

> The system is distorted. We hoped there would be a connection between work and money. But...the money doesn't get to us, there are too many questions. And if we don't pay our contributions, we don't get all the money. This financial problem is the source of all the confusion.
>
> Head of Krasnooktyabrskii *raion*, Volgograd.

That is, the incentive structures that were meant to operate – that health care institutions should receive money, according to one formula or another, for the quality and amount of services they provided – were not operating. The lack of funding makes maintaining day-to-day *operation* the top priority. The impossibility of establishing connections between quality of care and hospital income undermines the ability of the insurance companies to perform their main function of medical audit. Money cannot be withheld that isn't there.

The budget prioritisation by articles (sanctioned for budgets overall) hit healthcare particularly hard. The representative from the Volgograd Oblast' health care committee pointed out that when money in the localities is distributed, health care is in competition for social funding with education, culture and so forth. The first priority is pay. In education, pay is the dominant expenditure, but health care also requires funding for medicines, equipment and so forth. Thus in terms of *needs*, health care suffers disproportionately from commonly used tactics to cope with severe financing shortfalls. Preventive and public health measures to reduce long term expenditures are also accordingly under-funded.

Common to both regions was a general disappointment that the insurance system did not lead simply to additional funds coming into health care, but to part or near-full replacement of budget funds by insurance money; administrators had been sold (and accepted and supported) the idea of insurance on the grounds that it would be a "*plyus*", an additional source of financing. In Volgograd Oblast' the near collapse of budget financing for health care meant a reliance on the insurance system for all the needs of healthcare. Effectively, employers were funding not only the primary care of the non-working because of the inability of the municipalities to pay their contributions in full, but also target programmes such as tuberculosis, venereal disease and cancer treatments. As one administrator and supporter of health insurance put it, this was leading to a "misunderstanding" of how insurance works, and reduces support for it, as people blame the lack of money on the insurance system rather than on the budget system.

However, a difference should be noted between the two sites. Firstly, the financial and fiscal situation in Volgograd was reported as having noticeably worsened over the course of the 1990s, whereas in St. Petersburg respondents expressed a certain degree of financial stability (within the context of Russia), albeit a situation of stable shortfalls. While in St. Petersburg respondents on the whole expressed the financial problems as being temporary, and certainly dwelt on them less, in Volgograd Oblast' the chronic lack of money appeared at times fatal to the system of insurance as it was constituted. One should remember that part of the shortfall in Volgograd Oblast' was made up of inter-accounting

(cross-cancellation of mutual debts across institutions) and promissory notes, as well as some payment in kind, such as food procurement. Part of the relative stability in St. Petersburg may be down to the existence of Petrovskii Bank, set up at the beginning of the insurance system in order to act as account holder for all the healthcare units in the city. In effect, the health care system was afforded some protection from the collapse in the banking sector following the August crisis. Similar protection of accounts in Moscow at the behest of the pro-active and authoritative mayor Yuri Luzhkov enabled the continuation of funding at a far higher level than might otherwise have been possible, avoiding severe disruption (Reshetnikov, 1998). However, it should still be remembered that for a sector learning to rely partly on imported goods, a 75% reduction in the national currency would have an impact no matter the financial arrangements. In common with some other respondents (notably the trade unionists) support for insurance in principle was qualified with the experience of it in practice, in the context of the financial collapse. The phrases "at the wrong time", and "not in these economic conditions" were particularly frequent. This is in keeping with the survey mentioned above: 38 of 78 regional health care chairs (49%) questioned felt the insurance system was "necessary, but not yet of its time" (MG 31.3.95/4) – more than any other response.

In particular, in Volgograd and Volzhskii, there was particular criticism of the complex financial structures that had emerged.

> There are too many links between insurant and the health care unit. First there is the insurance company, and then the fund filial, and these both have their costs to maintain, and then there is the Oblast' fund which also has to maintain itself. And then there's the federal fund.
>
> Head of Dzerzhinksii *raion*

Four out of the six administrators in the study specifically expressed a preference for the original system where the fund had a minor role, and where most work was done with the insurance companies,. They were seen as more responsive, the flow of money seemed to flow more transparently. (It should be noted that the contribution rate was also higher). Notably, none referred to the chaos that developed in this original system as described by the deputy director of the territorial fund, the head of the association of insurance companies, and indeed newspaper reports, that led the federal fund to threaten withdrawal of subsidies unless the territorial fund was reformed and strengthened. Part of this preference for the original system may have been the ability of the administrations to develop working relationships with the insurance companies (they were often housed in the same building as the healthcare department of the *raion*). The head of Krasnooktyabrksii *raion* in particular stated that "we have our insurance company, we work with them well, we know each other". By contrast the municipal administrations have no right of exit from the territorial fund's

jurisdiction. It is perhaps in this light that opposition to the territorial fund was expressed just as often (although sometimes in a more guarded fashion) as opposition to the insurance companies.

The representative of the Oblast' committee was by contrast more hostile to insurance, seeing the system as partly responsible for problems of finance. Its emphasis on the decentralisation of health care and the complication of financing into state, insurance and fees had led "not to a health care system, but to an under-funding of health care". The division of financial responsibility for curative and preventive measures had, she argued, undermined the integrity [tselostnost'] of the health care system, splitting it into state, insurance and privately funded, thereby diminishing the ability to rationalise and economise.

A converse situation can be seen in St. Petersburg where the federal blueprint was ignored in favour of insuring the population purely by territory. This was supported by all the heads (as well as every other health care actor in the city) for the sake of simplicity and economy. In common with other respondents in the city (including insurance company representatives), the administrators felt that to have moved to giving employers free choice of insurer would have been an excessive administrative burden: there would be thousands of contracts with insurance companies – instead of one or two – over any one territory. Moscow City found that administering health insurance which varies with one's job rather than one's place of residence (both companies and jobs in the 1990s were far less permanent, especially in the tumult of the Muscovite economy) has demanded the urgent development of plastic card technology to cope.

Decision-making structures

Respondents were invited to comment on the decentralisation of health-care decision making, with the new legislative authority given to the federal subject (the Oblast', St. Petersburg city) and the executive discretion given to the municipalities. They were asked to reflect upon conflicts between the different levels (federal, region, city, municipality), the extent to which relevant decision-making processes were open and accessible, and to what extent decentralisation threatened the integrity of the system.

Here there is a striking difference between the sites. In St. Petersburg there is general contentment with the *structure* and *manner* of decision-making within the city, if not always the decisions that are made. All but one of the administrators there cite the city healthcare committee (under the auspices of the governorship) as quite clearly the leading actor in health care policy. They also all stated their faith in the openness of its practices, insofar as they all have a vote on the committee, and there appears to be no particular cabal or inner

circle within the committee. The influence of different *raiony* seems to depend upon their size and whether or not they take part in experiments with the supervision of the centre. However, this seems not to cause resentment in other *raion* heads, who see this situation as perfectly rational. Several of them mentioned and appeared happy with their contribution to the St. Petersburg *Conception of Development in Health Care 1998-2003*. (One interview with a city-centre *raion* committee chairman consisted mainly of being shown particular chapter headings in the document to save time. His more than mine.) Indeed, the consensual, pluralist flavour of St. Petersburg health care politics[1] is evidenced by this document, supported by the signatures of *all* actors in the health insurance system – administrators, insurance companies, the territorial fund, the trade union and the medical association. What complaints there were, were with the federal level. Laws governing the insurance system were held too vague; decisions were left to federal subjects and their municipalities that should have been made at a higher level.

In Volgograd Oblast' we see a similar consensus within Volgograd city itself, although the heads do not necessarily have the same formal influence over all decisions. There is also scope for co-operation between the *raiony*. The head of tsentral'nyi *raion* health had been particularly active in encouraging the formation of a city-wide insurance database. However the Oblast' is another matter. It is seen as distant, indecisive and weak. One *raion* head claims to have practically no contact with them. Another complains of the complexity of the decision-making system.

> There isn't enough flexibility in the system. There is a large ladder: there is the ministry, the Oblast' health care committee, then the city committee, and then the *raion* and finally all the hospitals...this step-level system of authority is very long-winded. If there is a decree, it takes three months to be enacted.

In Volzhskii the head of health care reflected that

> The Oblast' committee is the higher institution, but...speaking crudely, we're hired by the mayoralty, and here we have our equipment and our healthcare provision. Financially there's no help. We were industrially a strong town, and although industry is now faltering the Oblast' has never helped the town. Quite the opposite, we help the Oblast'.

The head of the Volgograd healthcare committee accused them of being held back by "conservatism and the fear of taking decisions".

The Oblast' itself faces difficulties in governance created by the law on local self-government and weakness in the budget. The chief health care analyst on the Oblast' committee talked of the difficulty, in the absence of concrete legal sanctions, of enacting a

[1] By contrast high electoral politics in the city have become fairly violent in recent years.

co-ordinated policy across the Oblast'. Rational argument is not enough, as many of the local administrations lack expertise in health care.

> There is an administrator occupying an elected position-someone with a technical education. His deputy in charge of social questions might be scientifically educated, but he doesn't know anything about health care. He knows about the social sphere in general, but he doesn't always understand the subtleties of organisation of health care. There are certain laws and good practices, preventive measures, primary health care, and so on and so forth. Sometimes the person in charge doesn't understand these matters... He understands that you need to pay people. But governance issues are left to the head doctor, who may go to him and say, "I need you to finance public health programmes, vaccination *etc.*". The man answers, "there's no money. I paid you already, and that's all." Insurance medicine pays for insured incidents, when people fall ill. But health *protection,* public health... must be financed only from the budget. Unfortunately, there isn't money in the budget. And to persuade the finance bodies that funding these programmes would be easier and cheaper than subsequently treating the sick is often impossible...There is a lack of knowledge, incompetence on the part of the specialists.

In effect, the Oblast' only has direct control and influence over those specialist institutions – the oncological hospital, the Oblast' clinical hospital and so forth – which were legally subordinate to the Oblast'. Other institutions, at federal and municipal level, answered to others. Thus in Volgograd Oblast' the decision-making structure appears to be both complex and weak. Legislation is not brought forth, co-ordination between population centres can depend arbitrarily upon personal relationships and expertise both between and within levels of government, and critically under-funded budgets in the localities prevent appropriate investment and action. Commonly respondents said simply "*net rychagov*", ("there are no levers") for the Oblast' to exercise authority through control of the purse-strings. The deputy president of the IMO association had put forth in seminars the use of the Oblast's institutional and professional accreditation powers to exercise leverage over institutions – a rather severe measure in conditions of shortage – a suggestion "for which I was nearly killed".

However there are concerns about the increasing influence of the territorial fund and its opaque operation. The reform and reassertion of filials across the Oblast', and the 1999 sidelining of insurance companies as mere auditors rather than financers has strengthened the fund's ability to govern, and removed from the municipalities any formal or informal influence over the control of insurance money. As the head of Dzershinskii *raion* put it:

> When we contracted with just the insurance company, we could negotiate with them about various conditions, but with the fund such negotiations just don't happen, because it's an organisation, which isn't very accessible for all insurants. It was easier to work with insurance companies than it is now with the fund filials.

According to the head of tsentral'nyi *raion*, "everyone is trying to monopolise", with the funding "taking too much on itself...without responsibility". Thus the power vacuum at the

centre of Oblast' health policy is apparently being filled by the fund, whose financial muscle grants it a position of prominence. It is an alternative power structure that alienates the administrators at the local level and is far less accountable. This matter is looked at in more detail in chapter eight.

In both sites there were those who mourned the loss of the vertikal', the strict executive discipline of the Soviet Union, which had been undermined by decentralisation both of decision-making and state property ownership. In St. Petersburg, the head of Petrodvorets with a background in the army expressed the situation most simply, although in reference to Russia in general, rather than to the situation in St. Petersburg where a certain centralisation of authority in the federal subject – the city – had been maintained:

> [The old system] was a trustworthy and stable system. Most importantly there was a strong line of responsibility from the lower to the higher. People were held strictly to account. Now unfortunately it's not like that.
> *Why?*
> Because every Oblast' and *raion* has their own [health care] heads, who are legally subordinate to the head of the administration. For example, I answer to the head of the administration. If the [higher] committee says one thing, and he does another, he says to me – I am responsible for what you do, so do as I say.

This decentralisation extends to the appointment of the heads of health care institutions, who are therefore controlled at both the institutional and the personnel level by the municipality.

Moreover, in moving from a strong command structure to a decentralised and pluralist system, there is a profound culture change. Problems have to be solved by legislation and co-ordination rather than by direction; behaviour has to be regulated rather than controlled. Those accustomed to systems of rule by fiat suddenly find the tools that they are used to using or experiencing (and *quite reasonably* they would wish to continue with these instruments) are no longer available, and that the new ones are a little unwieldy. This move, generated in part by ideological shifts in approaches to managing society (cf. chapter 3) has hindered those elements of command structure that remain. The Chair of the Petersburg Head Doctors' Association commented:

> Well, people of my generation, we have a fear of *prikazy* [executive orders]. In Soviet Times, if you didn't fulfil an order, you got into trouble, any piece of paper, give an answer within this time *etc.* But people of the younger generation, they look at them with humour, they simply say, "let's bin it" and so on.

As a general comment on Russian society, the émigré sculptor Ernst Neizvestnyi argues that there is a confusion between *svoboda* and *volya* – freedom and wilfulness[2] (*Argumenty i Fakty* 1998). Similar comments about regional politics were made by the deputy head of the

Volgograd territorial fund, commenting that local leaders behaved like "tsars in the localities" (cf. chapter 8).

However, other Soviet habits may remain. The head of health care in St. Petersburg's Admiralteiskii *raion* in Petersburg reflected on the Soviet legacy of the personalisation of power in a less hierarchical system. "People don't divide their professional and personal lives...they let personal relations influence professional decisions." In a hierarchical system this is more manageable, as at least the chain of command does not need to be broken. In a negotiated system where one cannot control so easily those from whom you request action it can lead to gridlock.

For when considering this process of empowerment of lower levels and the chance to take responsibility for actions and initiatives, one should remember responsibility is not simply introduced *de novo* into a system that infantilised administrative actors, it is also introducing a different kind of responsibility. One does not simply (if at all) have more freedom to give orders at a lower level; there has to be co-operation and lack of obstructionism on the part of others. For any country such arrangements could be problematic, and more costly than the efficient execution of orders. Again, the chair of the head doctors association in St. Petersburg:

> "There is not one person in charge of the system. Many structures take part [she cites the ministry of health and the federal fund as examples], and all have no responsibility for anything."

It is in the light of these factors that nervousness, such as that of the representative of Sovetskii *raion* in Volgograd, about the "flexibility" [gibkost'] of decision-making structures should be understood.

As predicted in Chapter four, decentralisation has undermined public health measures. The Volgograd Oblast' committee representative stated that

> The vertikal' helped us govern the system, in a good sense. Health care is not simply about curing; there are aspects which have a healthcare, a prophylactic aspect, which ...have to be considered – health education, vaccination, getting the population to go to medical check-ups and so on. This is centralised work, work to do with social problems: tuberculosis, psychiatric problems, venereal disease and so on. This is *serious, state, integral* work.

In particular, the ability of the Oblast' to monitor the spread of venereal disease had been undermined by a lack of co-ordination on reporting cases, exacerbated by unpreparedness for institutional innovations such as the right to anonymous treatment. (The same case visiting two different institutions may be counted twice).

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[2] Unfortunately the distinction in meaning is somewhat sharper in English than it is in Russian. In other close Slavic languages (*e.g.* Ukrainian) *volya* is indeed commonly translated in rhetoric as "freedom"; my translation here is thus for contrasting purposes.

However, others welcomed the new freedom to act locally, especially in terms of innovation, enforcement and defence of local interests. The head of Kirov *raion* health care in St. Petersburg welcomed the ability to conduct municipal experiments in health care organisation, piloting projects such as payment by case and the introduction of general practice, with a view to expansion to the whole city. The horizontal gathering and exchange of information, the dissemination of best practice was a key interest of the head of tsentral'nyi *raion* in Volgograd. In St. Petersburg four of the respondents felt that decentralisation was important in order to give responsibility to those enforcing the law on the ground. In Volgograd, the heads of two *raiony* felt that operation with the insurance company helped increase possibilities at the local level. In Volzshkii, a relatively wealthy city in the Oblast', the decentralisation was seen as an opportunity to safeguard the city's funding, although moral considerations (she cited the Hippocratic oath in particular) militated against withholding resources from other parts of the region and their residents being treated in Volzhskii. (Of course, one should remember that in the mid 1990s such defence in Volgograd Oblast' also resulted in the chaos of 44 filials and the degradation of the insurance system.)

But all of the respondents in both sites, albeit more strongly in Volgograd Oblast', expressed the view that the legislative framework enabling the health insurance system was inadequate and sometimes counter-productive. In particular the setting of insurance programmes, prices and guidance on how to deal with insurance companies had not been clearly laid out certainly by the federal authorities, confirming the inertia within the central ministry reported in chapter five. Many such tasks also had not been carried out by the Oblast' authorities either.

Responsibilities and finance

Part of the decision-making "problem" emanates from the asymmetry of rights and responsibilities in regions like Volgograd Oblast'. Post-Soviet decentralisation of health policy and property to lower levels of government, and attempts to pluralise financing have detached policy-making and resource management from each other. In particular, those who determine the rules of the game (prices, social priorities and the content of the basic programme) – the federal centre and the Oblast' committee and Duma – are not those directly responsible for funding and operating the system. Therefore they carry little practical responsibility for the results of their directives. Furthermore, influence over the centre from the region, and over the region from the locality is, as examined in the previous section, weak, to say the least. In the context of Volgograd and Volzhskii cities, the relationship with

the Oblast' could occasionally be characterised as hostile, and arising so partly out of unresolved (irresolvable?) structural-economic inequalities in these relations. Furthermore, in conditions of money-shortage, it is only to be expected for the authorities to apply the pinch where they themselves will feel it less. I examine a few cases of this general problem.

The federal centre and the Oblast' have the power to determine social priorities – such as discounted or free medicine for veterans. Crucially, the responsibility for rendering most of these services lies with the *raiony* and the municipalities. Even though if money in full is not forthcoming to support them, the municipalities and *raiony* are obliged to follow the law. Such concessions are often made for political purposes, with little regard for the expense. To make matters worse, it was also reported that with the advent of insurance, money from the Oblast' for target programmes (against TB, drug addiction *etc.*) was withdrawn – even though the insurance system is not meant to cover these items. Again, these programmes by law (and medical ethics) have to be fulfilled. There have even been responsibilities moved onto the *raiony*, for example, obstetrics and child public health. In each of these cases, actions by the higher level of government have resulted in extra financial burden upon the localities without there being relevant financial compensation. St. Petersburg suffered these problems far less than municipalities in Volgograd Oblast'. Most concessions and social programmes are designed by federal subjects. St. Petersburg city, having direct responsibility for finance as well, had greater incentive to co-ordinate planning and finance.

Secondly, within Volgograd Oblast' the unequal distribution of finance and sometimes "lumpy" healthcare infrastructure (where specialist centres serve the whole Oblast', but are situated, obviously, only in one place) clashed with the legal and moral obligation to treat patients from whatever part of the Oblast' they come. The poorer municipalities often could not pay for their patients, nor could the Oblast' afford to underwrite such exchanges. (Often this was for treatments not officially covered by insurance). Furthermore, the decentralisation of ownership/management meant that specialist centres that were meant to serve the whole Oblast' were often under the responsibility of one municipality or *raion*. Attempts to move them to Oblast' jurisdiction are met with opposition. For example, in Krasnooktyabrskii *raion*:

> We have a child sanatorium and we wanted to move it to the Oblast'. We tried but they wouldn't agree. You see, there's a sanatorium in every *raion* for one condition or another.

The moral imperative to see people are treated had led, according to the deputy director of the territorial fund, to the fund allowing insurance money to be used for non-insurance purposes. Indeed, it is this kind of material inequality that has led the fund to reorganise its

own territorial (filial) division of the Oblast' as part of its general assertion of authority over the state of health care financing.

Again in St. Petersburg these problems are far less severe. To begin with, the difference in wealth and character between *raiony* is less, and mediated by financing originating from one single unit. Secondly, one can characterise the territorial fund as clearly working in partnership with the city authorities. Use of insurance money for non-insurance purposes (where budget financing falls short) can be sanctioned as co-ordinated investment in tackling public health, rather than as a unilateral and possibly irredentist safety net. This controlled, considered use of funds strengthens the legitimacy of the divide between insurance and non-insurance health care. Lastly, although many health care units are the day-to-day responsibility of the *raiony*, the city is ultimately responsible for their maintenance. There is no clear financial gain for the city government as an institution by pushing away responsibility for maintenance of municipal institutions. Indeed, according to the health care committee and the head of Kirov *raion*, the city has been trying to persuade the federal centre to allow the city to take control of some federal institutions (Russia-wide specialist centres) in order to maintain them better, and to allow easier access to them for ordinary citizens through the insurance system.

A third and crucial problem that affects all the federal subjects is the determination of the basic programme in health insurance – where those writing federal and regional minimum coverage programmes for insurance make no reference to available resources. The deputy head of Moscow Oblast' healthcare (MG 18.9.98/5) put it most succinctly "we rely on residual funding, but operate on an expenditure principle". Thus the basic and territorial programmes are described often as "declarative", as what they contain, and what finances will allow are two entirely separate matters. The pressure on other non-insurance health care expenditures, and the semi-legal use of insurance money for those purposes only serves to muddy understanding of what is available through one's health insurance policy.

As a result, the insurance mechanism, where money follows the patient and reflects the cost and quality of care, is undermined. Both in St. Petersburg and Volgograd most administrators appear, regretfully, to recommend increasing the services for which patients must pay at least something, as well as moving more peripheral treatments (usually dentistry and cosmetic surgery) out of insurance. In both sites administrators talked of "honesty" and the need to "tell people they will have to start paying". This seemed to be motivated partly by a desire to connect revenues to services in a way that the insurance system was failing to do. Partly, it was to get the population more involved in worrying about their own health.

Moral problems and economic motivation

Indeed, in both regions, administrators dwelt at length on the moral and social problems in society, which affected both patients and those providing them with care. Although no one else went as far as the deputy vice-president of the Volgograd Insurance Medical Organisation Association in referring to the old – Russian – adage of all Russians being "thieves", age-old concerns about the civility of Russians and their tendency to moral anomie (which has long been used to justify autocracy as the best form of government for them[3]) had certainly been re-ignited by the social and physical disorder they now encountered. One Petersburg administrator referred to the "moral and psychological problems" in the population that led to poor parenting, and the high levels of alcoholism. Undoubtedly risk behaviour has considerably increased (cf. Chapter 3). Concerns were also raised about the professionalism of some doctors and the subsequent quality of care they rendered, as well as their interaction with the insurance system.

The sources of these problems, as expressed in the interviews, were varied and at times contradictory. Some indeed put many problems down to the eternal Russian anarchic condition – affecting both doctors and patients. Two administrators in Volgograd and one in St. Petersburg referred to a well-known story by Mikhail Saltykov-Shchedrin that is often cited as an expression of Russian indiscipline. The heroine, Tat'yana Yurevna would be asked, "Babushka, may I steal this apple?" "No." she would reply, "It's forbidden". "But if I *really* want to?" insists the small child. "Well, if you *really* want to, then..." Another, in Petrodvorets looked at the problem more historically:

> Judging by the history of your country, for 150, 200 years you've brought people up to be law-abiding. It's the same in France and Germany. But in Russia thus far law-abidance hasn't really been established. So if the law says 'do this', some of our people search for ways of getting round that law.

That is, establishing any system of rules in any organisation or social group in Russia without the application of firm discipline might prove difficult unless the character of the people changes. Such reflections are no doubt part of the desire for the return of the *vertikal'*.

However, this rather pessimistic view (although usually expressed with a smile) was only part of the source of the problems. Some problems were supposedly inherited from the Soviet system – for example the "soviet mentality" that resulted in opposition to reform and

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[3]Both Conservatives such as Tsar Nicholas II's tutor Pobedonostsev and liberals such as Bertrand Russell have in the past explicitly subscribed to this idea (Figes 1996:7), as well as modern nationalists such as Zhirinovskii. Pipes (1995) argues that many narodniki (the 19th century romantic nationalists who wanted to mobilise the peasantry) were disenchanted when they came into contact with the brutal amorality produced by serfdom; those partaking in the discourse of Russian identity have thus long been preoccupied by the possibility of latent lawlessness.

change. In St. Petersburg there was a particular preoccupation with patient passivity generated by the moral hazard of free health care. "Everyone has this old idea: care is free, care is free, care is free" (Vasiliostrovskii *raion*); "the patient needs to be interested in his own health" (Nevskii *raion*). Again, the head of Petrodvorets was articulate on how this passivity had been reinforced throughout the system:

> The problem is, that, our previous system allowed independent of material situation guaranteed average health care, maybe not of the quality in Sweden or England, but guaranteed for everybody. In the forest, on the sea, wherever, there was no problem...The problem was that health care took on the responsibility for people's health from conception till death, although the government didn't spend enough money. [However] it allowed specialised work at a very high level, and in general it was certainly satisfactory. But the problem was that if only we had had a cult of the healthy person, it would have worked even better. But no one really worries about whether or not someone is ill, no one was fired, one could get doctor's papers very easily. And so in the mentality of the population there was the attitude that if I fall ill, I'll get cured. People didn't worry about their own health. And only now they start thinking about how it's better to be healthy.

Why this should bother St. Petersburgers more than Volgogradtsy isn't clear. Perhaps other conflicts do not preoccupy them as much. Alternatively, it may be part of collective discussions to justify the introduction of fees.

In Volgograd there was more concern with the decreased emphasis on health and safety at work. The 1993 system, unlike the Volgograd prototype, gave no incentive to the heads of large enterprises that polluted or demanded difficult working conditions to improve their workers' health.

Other explanations offered looked at the difficulties created by the transition. For one, there was greed brought on by individualism: "These so-called market relations, the battle for money, and power it's divided our people, they fight each other. It's first of all money and then the rest." (Kalininskii *raion*, St. Petersburg). Others linked the increase in risk behaviours to increased poverty and social stress – alcoholism, poor family planning, drug abuse and crime. This put pressure upon medical staff, as they were put under pressure to act as "social workers" (Krasnooktyabrskii *raion*, Volgograd).

Poverty and perverse incentives also discouraged health care workers and institutions from working professionally and well. In simple terms, the lack of finance had forced doctors to accept more bribes. This wasn't something that many of the respondents were keen to discuss, despite widespread anecdotal evidence and acknowledgement of its existence. It was also a difficult matter for the insurance medical organisations to pursue, although representatives of these insurance companies were far happier to talk about it. In fact, there was a point of disagreement within these two groups as to the wisdom of "legalising" under-the-counter payments. While administrators talked of regulating payments to bring in extra funds, the St. Petersburg insurance company representatives felt that any

such attempts would only penalise the patient; doctors would still want bribes because whatever money was received would not go to the doctor but to the hospital funds. The vice-president of the Volgograd IMO association, on the other hand, supported legalisation, in spite of his own experience of misleading accounting on the part of the hospitals when presenting bills to insurance companies (cf. chapter 8). Curiously, administrators were far less concerned about social justice aspects of medical fees than were any other respondents in the study. They saw it as unavoidable, and possibly a moral good.

The lack of other resources also affected doctors' motivation and ability to work well. One Volgograd administrator (Dzerzhinksii *raion*) describes doctors as "hostages" in that they were fixed to outdated and ineffective practices. The head of Traktornyi *raion* bemoaned that it wasn't true that medical workers operated badly, they simply lacked resources. Notable was the express confidence of many respondents not just in the high quality of medical personnel, but also in their superiority to others in other countries, almost to the point of arrogance. For example: "But we don't have the technology. If we had the technology you, and France, Germany have, we would do better than you."

But there was also testimony regarding the problem of de-motivation and lack of care. A Petersburg administrator, complaining of the "incorrect" attitude of doctors towards their patients told how some doctors were simply "tired of seeing patients", and referred them onto whoever else they could. More worryingly, the system of finance, according to the head of Petrodvorets medicine had led to poor referral practices in the context of a morally weak society:

> The main principle is that the IMO per capita funds the polyclinic. If the polyclinic hospitalises, then it contributes to that treatment. So they have an incentive not to refer onwards. But when in society there is a high level of morality, high orderliness...[it's OK]. But we have an extreme situation in this country. There is an artificial holding of the patient in the polyclinic. So we have an increase in chronic illness. We think this isn't right.

Similar words were used by the representative of Kalininskii *raion*:

> I'm not talking about religion, but people need to be first of all, honest, orderly, work in line with your conscience. One needs to think not only about oneself but also to help others in moments of need. If there were these norms, then society would be very different

The problem was that doctors, under severe financial pressure, underpaid and de-motivated, were naturally more likely to follow perverse incentives against good practice. And undoubtedly, these problems were exacerbated by the operation of the insurance system. As examined in chapter 8, the methods used by many insurance companies worked further to undermine morale. By using seemingly (to medics) arbitrary and, to those operating within a shortage economy, almost vindictive methods, some IMOs have caused a great deal of resentment. In a heated meeting I witnessed of the head doctors of institutions in

Krasnogvardeiskii *raion* in St. Petersburg, the mention of insurance caused a mass of angry eyes to roll upwards. The carrot of earning more by working better, in shortage conditions, merely became the stick as the IMOs tried to extract money from the health care institutions. In effect, a system of fines was introduced without a system of bonuses. The very involvement of money seems absurd to some. The chair of the head doctors committee in St. Petersburg stated that ironically "it's now the task of doctors to earn as much money as possible".

Demographic problems

Decentralisation of insurance for the non-working to municipalities with populations of 100,000 or much less created demographic imbalances. As insurance money was being used to cover some non-insurance expenditures in both regions, the economic and demographic specifics of some municipalities became important. In Krasnooktyabrskii *raion* in Volgograd, two thirds of the population were either pensioners, children or unemployed. Although formally that should not have affected the amount of money paid out by the territorial fund, in reality, the fund would withhold payment in lieu of the debt on the part of the *raion* for such a large non-working population; other social needs ate up the budget as well.

Even in St. Petersburg, the variable size and position of *raiony* caused disparities in outlays. For example the Petrodvorets head admitted that his "dormitory" *raion* had few problems, few specialist institutes, and a population that mainly got treatment elsewhere during the day. Admiralteiskii *raion*, right in the middle of the city, suffered not only from a dramatically increased population during the day, but it also attracted social problems such as alcoholism, drug-takers and a concentration of social diseases. Much of this was compounded by up to 80% of the resident population living in *kommunalki*, communal flats that shared washing and kitchen facilities As a result, there was far greater pressure on the target programmes, and therefore greater pressure on the *raion* budget.

St. Petersburg as a reformist city and the influence of politics

Respondents in St. Petersburg were asked if they thought there was a particular advantage for St. Petersburg in its experience of previous reforms when developing a system of health insurance. There was near unanimity in the positive (one abstention). Firstly, the experience of the New Economic Mechanism, whereby health care institutions had to be self financing, with polyclinics acting as fund-holders had several advantages, and indeed, many wished to return to it as a better system than the insurance system. For one, the problem of establishing

prices for services had been solved then rather than later, and on principles more in accordance with cost. For another, and correspondingly, it treated medical institutions as independent, allowing the head doctors in these organisations the experience of greater freedom in determining finance and resources allocations. And as the head of Vasiliostrovksii *raion* put it, "in 1987 there was the first appearance of the understanding of medical services as goods", to which there had been a great deal of resistance. This is echoed by the chair of health committee in Voronezh Oblast'.

> We started to list [krenit'sya] five years ago, when we moved to the New Economic Mechanism. It was precisely then that we went through the most painful processes. Some rejected the innovation openly and directly, others through passive opposition tried to turn matters towards negative results. A third, the majority, were supporters. And they overcame the real opposition of the first two groups." So reform helped, not least in changing psychology (MG 25.10.95/7).

There was a general feeling that the experience of reform had in itself produced a good number of reformist thinkers. According to the head of Kolpino *raion*, Petersburgers are naturally "creative"; in Kirov *raion* it was felt that health care organisers in the city have always been proud to be in the forefront of every new development. While this last point may come across as vague, one should note that when asked to identify who has been most influential in the development of health insurance, in both sites respondents referred to particular personalities and groups. Even those opposed to the first St. Petersburg committee chair Valerii Koryukin conceded that his contribution was vital.

However, while a reformist tradition can be seen as important, having "reformist" politicians appears not to be so. Respondents in both sites were asked about the differences in health policy under reformist and pro-Yel'tsin politicians (Sobchak in St. Petersburg and Shabunin in Volgograd Oblast') and then more statist, leftist politicians (Yakovlev and Maksyuta respectively). None made *any* reference to the political position of the regional heads as impacting upon health care. Only the head of the Trade Union in St. Petersburg spoke of a deal struck between the union and Yakovlev, to sack the St. Petersburg health care chairman Valerii Koryukin for his increasingly extreme anti-union stance. In Volgograd no respondents could notice any particular difference between governors. In St. Petersburg, people referred to personal qualities. Where a difference was expressed, Yakovlev was seen as a more capable manager, and a better listener. Those who criticised Sobchak saw him partly as a mere "phrasemonger" [*krasnorech*], and partly as corrupt (allegations substantiated by the chief prosecutor's office). In both sites respondents said that health care was used as an electoral issue then forgotten about.

> Medical insurance in Volgograd Oblast' is simply a whorehouse[4].
>
> - *That's a very strong word.*
>
> I can't think of a better one.
>
> Head of social policy committee, Volgograd City.

Those administrators and head doctors with strong enough ears in both sites would certainly smile at this. Several were highly critical of how the system was operating. Yet in almost all the interviews when asked, "would the situation be better without health insurance?" they all answered no. This accords with the survey data both from various representatives of administrations across Russia, and within smaller surveys (*e.g.* Twigg 1998) that broadly support the introduction of health insurance. How can this paradox be explained?

There are two main reasons. Most importantly, insurance had provided a source of stable financing. The financial crisis in health care was not simply that there was little money in a poor country, but that even the proper, minimal, *appointed* share of funding was not forthcoming. Firstly, general tax collection rates have been as low as 20% at various times in the 1990s, (although of course social taxes such as health insurance have a higher collection rate). Secondly, health care funding at the municipal and regional level is subject every year to debate; its traditional residual budgetary status competing with other elements in the social budget, naturally leads to under-funding. As stated above, health care structurally loses out in such competition because of the priority placed on paying workers in the social sphere; expenditure on drugs and equipment is often not taken into account. Thirdly, the presence of insurance money has led some legislators to see it as an alternative source of funds and cut budget health expenditure even further. On the other hand, health insurance contributions, having an earlier call on the wage fund than general income tax has higher collection rates – up to 80-90% in the two sites studied here. The contributions work as a hypothecated tax, making income streams into the system more or less stable year to year (although the stability of the Russian economy and the money system is outwith the health system's control). Claims of waste and fraud can be calculated in terms of the share taken by the territorial funds and the IMOs; the site of corruption and waste is easier to identify and remedy.

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[4] Rus: *Bardak*. The word is of course meant figuratively to mean "complete chaos", but its literal meaning is used in translation in order to give an idea of its vulgarity. Not to be used in polite company.

Secondly, and it deserves emphasising, there was near universal support for the *principle* of insurance. As a mantra, many approved of the rule "the wealthy pays for the poor, the healthy pays for the sick." Many, especially in Volgograd, welcomed the logic of doctors being given the opportunity to be rewarded for more and better work. It seems to be a way of allowing them their dignity after decades of being poorly paid and not respected. Support was also expressed for an identifiable connection between those responsible for health conditions – either the employer or the individual – and those paying. Those who would be labelled as having a "Soviet mentality" by their opponents, those who sometimes called themselves conservatives in opposing current reforms, were especially keen to emphasise their belief in these principles. Very few felt that it would be ideal to return to the previous, Soviet system, and recommendations to do so were only as a stabilising stop-gap in crisis conditions.

Thirdly, respondents felt that health insurance was tied up with being part of a market economy – that to want to go back to the old system would mean returning generally to Soviet times – a matter dealt with in chapter 3.

Objections to insurance were to how it had worked *in practice*. The centre, as seen in the previous chapter, has been indecisive, out of touch and somehow distanced from the insurance system. The level of contributions is too low. Normative documents regarding tariff-setting, the basic programme, cross-border flows of patients that should have come from the federal centre either had not appeared, or were too vague, or were overdue. Co-ordination with other ministries and laws had not been forthcoming. The chair of the Petersburg head doctors association opined:

> We write a law on health insurance that the employer will pay 3.6% pay. Everyone knows that in no country is the contribution so low. At the same time we tell the population that they will get free health care. But how? It depends on the Economics Ministry. For example we have 8 roubles for medicine for each patient. If there's only a drip and a syringe, it's not possible to render good health care. The Economics Ministry simply wanders off, it doesn't take part in forming the insurance law. So we have this compulsory insurance law, and we have the constitutional guarantees, and the Economics Ministry treats it as if it isn't their business. So the law isn't worked out properly. [Another] example: we promise excellent care of patients, but how are we supposed to have excellent patient care if there is only one nurse for twenty patients. The Labour Ministry has such a norm. No one in the Ministry of Health Care takes responsibility. Everyone knows that the law is ridiculous. No one knows "whose" law it is. No one is overseeing its operation, there's no one, as there would have been in Soviet times, who could order people about, make phone calls, get things done.

Meanwhile, the Nevskii *raion* health care head (St. Petersburg) complained of the "opacity" of the central ministry's decision-making processes.

Secondly, and in Volgograd Oblast' especially, new local government structures made health-policy co-ordination (including insurance and public health) exceedingly

difficult. Rationalisation of resources, necessary in a system that emphasised efficient use of resources, was made very difficult. Cross-boundary resource flows were controversial as richer and poorer parts of the Oblast' were naturally in conflict. Policy setting and policy financing had become divided, creating policy targets that were not funded nor realistically could be expected to be so. Insurance was held to be part of this complicating process, creating new institutions that harried practice staff, and a fund that absorbed functions without proper democratic oversight. Strikingly, there was a strong impression given in the interviews that St. Petersburg administrators felt much stronger "ownership" of policy than in Volgograd. This difference seems directly rooted in the government structures. The Oblast' authorities were not open and accessible.

Thirdly, the chronic budget crisis, in line with the low level of insurance funding, transformed the supposed incentive system into a punitive reinforcement of the redistributive system, as expressed by the quotation from Vasiliostrovksii *raion* earlier in this chapter. While the Economic experiment in Leningrad (as was) and the initial Volgograd system pay was able to increase, and resources (at least in St. Petersburg) were beginning to be rationalised effectively, the current tight financial system prevented proper variation in funding according to quality. Attempts to audit exacerbate budgets, and so the IMOs, symbolic of the new system, were deeply resented by many doctors, and mistrusted and not respected by the administrators.

Fourthly, there had been too little preparation for the new relationships between organisations. Price setting and medical audit in Volgograd Oblast' had to be developed from scratch. As examined in chapter 3, the introduction of real prices into what was previously a pure command system is incredibly difficult. St. Petersburg's experience in the late 1980s aided the city substantially. The rules of medical audit had not been established, resulting in regions and IMOs experimenting with sometimes inappropriate methods of account assessment. It should also be remembered that in a system where there had been few checks on control in the past, opposition to medical audit might be "cultural". Surveys have suggested that medical personnel were not "prepared" [*ne podgotovlenny*] for health insurance (*e.g.* Twigg 1998; according to the 1995 Meditsinskaya Gazeta survey 31% of health care heads felt that the "psychological unpreparedness" of medical staff was the key difficulty in introducing insurance); the head of the Pskov Territorial Fund said that auditing is not considered prestigious enough to attract the best doctors, and is poorly understood by them (MG 15.4.98). However, even representatives of IMOs in the interviews admit a certain degree of incompetence is to blame for the dissatisfaction with external medical audit. The imposition of the standard insurance system on Volgograd, and the subsequent expansion of

the territorial fund's activities disrupted those developing relationships and practices that had begun to form in the early 1990s. Although the more guided model of insurance in St. Petersburg has not experienced these disruptions, both face the paradox that increased regulation of medical audit resulted in standardised approaches audit, undermining competition between insurers.

Lastly, the administrators in Volgograd Oblast' found the system too complex, in terms of operation and finance. There had initially been too many insurance companies for some administrators, a problem exacerbated by the territorial-productive principle producing complex relationships between administrators as clients and providers, and the insurance companies. The fund and the IMOs performed the same function (unlike St. Petersburg), and with previous more satisfactory experience with a very weak territorial fund and many insurance companies, and also Soviet experience of a strong vertikal', they tended to feel that either one or other of the two types of insurance organisation should be eliminated. In St. Petersburg there was not this problem; there was a clear division, reinforced by the behaviour of the fund, between fund collection and medical audit. The territorial principle was defended by all I spoke to; what varied was only their estimation of its longevity in the face of legal challenges by individuals and organisations un-named.

As a broad statement one may say that St. Petersburg administrators are far more inclined to support their insurance system than the *Volgogradtsy* theirs. This stems mainly from the simplicity of the territorial insurance principle, the structure of governance, and the readiness of the city for market-style relationships. The impact of these factors makes assessment of the impact of difference in financial capability very difficult to assess. There is a good deal of evidence that local health care management structures welcomed the advent of insurance as a good welfare principle and as a method of increasing finance. Resistance to change *per se* cannot be cited as a reason for problems in the system.

In the final analysis, whether or not these health care managers liked working with the competitive insurance model in state health care is possibly the wrong question. A mass of problems result from its incomplete implementation, its under-funding, and incompatible local government structures. Most health care managers have expressed a desire to make the system work; it is another question whether it can.

7. The Professional Organisations: Unions and Associations

The two faces of the Russian Health Care State?

In the reform of any developed health care system, professional bodies have played a dominant role. Indeed, Moran notes, "The analysis of the relative power of organized groups, especially occupational groups, has always formed the bases of studies of health care politics." (Moran, 1995: 753). But in Russia of his "three faces of health care" – technocratic and organisational issues surrounding care provision, the embeddedness of health care in industrial capital accumulation, and the societal conflict over resource distribution between capital, labour and the medical profession – the third is characterised by a curious emptiness. There was no mobilised participation in the design of the health insurance law on the part of professional organisations – neither on the part of the medical profession seeking to maintain market power or state privilege, nor indeed on the part of labour in general seeking to establish access to healthcare for their workers – neither as providers nor as purchasers. This chapter focuses on the providers.

Industrial action in the 1990s has been surprisingly low-key given economic conditions, and not usually seen as particularly effective. Furthermore such action is controversial within the medical profession, with many unwilling publicly to support withholding care from patients. Adjustments in methods of hospital reimbursement, control of funds, determination of prices, external audit – have all been done without the significant participation of trade unions, save through statutory representation on various committees and boards, representation which, the interview and other material suggests, is frequently ignored. Once the insurance law was passed, which ring-fenced a certain proportion of funding (and one lower than international practice would suggest), attempts to secure resources are not usefully explained as a societal battle of resources as in Moran's model. Instead, the collapse in budget financing suggests that what *has* been provided might best be understood as a response to the urgency of funding medical care – the meeting of a social need, constitutionally underwritten, whose expression gains no additional understanding when considered in terms of a compromise between interested actors. The moral imperative of not allowing the health system to collapse completely appears to play just as important a role at this level of financing as does the ability of various actors to lay claim to resources[1]. The biggest conflict over resources has in fact been between different branches of

[1] The head of the Volzhsky IMO, for example, talked of the need to finance those units which could not pay their way because "we can hardly not treat them... We've all taken the hippocratic oath".

government – the parastatal territorial funds and administrations over payment for the non-working.

In other systems, organised professional and labour interests have played a vital part in establishing the coverage and method of health care financing. Professional interests in particular have been strong. There are several reasons for this. Firstly, the socialisation of doctors in medical schools creates a strong basis for co-operation against "outsiders", consolidated by their role as experts. Secondly, as experts laying "claim to a growing monopoly of knowledge of increasingly esoteric and specialized techniques" (Heidenheimer *et al* 1990: 64), they can therefore lay claim to being the proper administrators of their profession, controlling licensing, standards and professional training. Thus self-regulation and peer assessment will dominate. Therefore there have been resources for cohesive co-ordinated resistance to health reforms that would economically disadvantage medical staff. Of course, as Immergut (1992) points out from her study of France, Sweden and Switzerland, the ability of the profession to exercise influence depends upon political decision-making structures – the organisational basis of political parties, the presence of coalition or majoritarian government, the ability to access decision-making directly through referenda, the absence of other over-riding political cleavages such as ethnicity, and so on.

Evidence of this strength litters the health reform literature. In general the professional associations have sought to oppose attempts to limit their ability to earn money – either through resisting global reform, or adjusting significantly reforms that are past, or simply tinkering to improve their lot. This ability varies according to the financing model in each country, with the more marketised systems providing the best opportunities for medical professional interest groups to assert their interests. This coincides with Moran's approach, where the noticeable role of the association in two separate arguments – distributional and economic – aids battles in each. The American Medical Association have been notoriously successful at "resisting national health insurance and maintaining a dominantly private and voluntary finance system" (Starr 1985: 6) – thereby avoiding most particularly severe caps on the fees that they charge. Yang (1996) cites professional interests as the biggest obstacle to better access and equity, and lower costs in South Korea. In more étatised insurance systems (which by their existence suggest that the medical profession has been to a varying extent co-opted and is therefore institutionally weaker) opposition to increasing limits on their independence is still strong. Reform in Greece in the 1980s was frustrated by professional resistance to non-medical personnel being involved in finance and planning – similar to the Soviet legacy of administration being dominated by medics. 1990s market reforms also had to be softened (with increases in salaries and limited tenure only for new

doctors) to appease the profession (Tragakes and Polyzos 1998). Although unsuccessful in its opposition, the Canadian Medical Association has sought to frustrate universalising reform both by challenging legislation, and seeking to set up parallel systems for richer patients (Kluge 1999). Glaser (1993) reports "tense periods" between sickness funds and medical associations in France, when doctors would not comply with fee schedules and contracts, and surcharged patients. Immergut reports that German doctors "have been able to receive extraordinary concessions during the legislative process" (1992:240) despite the implementation of some very effective cost control measures, and are among the highest paid in Europe. In National Health systems such as the UK doctors through their associations have been able to exert influence through their clientelist position with government agencies (Döhler, 1991).

The one system where there appears to be minimal conflict between provider interests and others is in Sweden. Immergut's (1992) analysis does indeed suggest that the Swedish use of commission representation for professions minimises opportunities for veto and outright opposition, through co-opting. Interestingly, the evidence suggests that where there is support from other institutions to express resistance, or where there have been attempts to end committee representation, union strength has still not shown itself. Saltman (1999) suggests that the Swedish medical profession grew up with a public service ethic under state sponsorship, as the pre-state system was – as in Russia – small and unsupportable by a sparse and rural population. However, such motivations appear weak in Russia: variable ethical standards and hierarchical oppression evidence a lower public service ethic, and the preparedness of medical administrators to charge patients when compared to other actors suggests a weaker commitment to equality than such a comparison with Sweden would suggest. Furthermore, spending on health in Sweden, although kept lower (in international comparison) by organisational aspects, is certainly far too high to be called residual, and the emphasis on hospital care suggests that, as Bergman says, "professional influence in health care is still strong and will remain so" (1998: 102). Although the Swedish medical profession is not strongly organised *in opposition to* the state, it can effectively lobby as an institution, and as a whole is able to garner more resources. It is arguable whether the other problem for Swedish interest groups – the political system that produces majoritarian government that can be more resistant to pressure-group politics – is also present in Russia. At the centre in the 1990s has been a deeply divided polity, with attempts at reform in the social sphere often frustrated. Outright opposition to the health insurance system – the refusal to produce accounts, to adopt price mechanisms, for example – would surely have led to some kind of suspension of the law (other problems such as the lack of IMOs, and of live cash have been

dealt with at the federal level rather rapidly). Concerted, moderated opposition aimed at certain policy outcomes, such as favourable payment mechanisms or the nature of external medical audit in a system where guidance from above was typically sparse and vague, and clear policy guidance across the whole of Russia *would possibly have been welcomed.* Instead such policy outcomes, rather like the original law, appear to be generated by technocrats and academics – and then imposed.

The further curiosity of this absence of vocal and/or effective organised professional and labour interests in Russia, is that as Immergut (1992) has suggested and the survey above supports, a health insurance settlement (as opposed to a national health system) reflects *greater* autonomy and influence over health policy for the health profession. They maintain their independence from the state, and far greater rights over the determination of price and organisation than in a national system. Indeed, as suggested in Chapter 3, the use of social insurance models for social policy in Russia reflects the imposition of a compromise on parties who were not in institutional or other organised conflict. This is not unusual for Russia. The Soviet system created structures that had the appearance of workers' control over production; the desire to be "modern" (a blanket term [*sovremennyi*] commonly found in texts advocating reform) perhaps means creating structures that give the appearance of a grand social democratic compromise.

In seeking to understand these issues, in this chapter I review material concerning the two kinds of groups claiming to represent the interests of health care providers in the two sites, and in Russia as a whole – the trade unions of medical workers, and the variably nascent medical and doctors' associations.

The Trade Unions

"Just a load of strike-breakers"

Member of Volgograd City Social Policy Committee

"They're petty little strikers"

Head of healthcare in a St. Petersburg *raion.*

While both are conditionally opposed to compulsory health insurance for largely similar reasons (that the condition of the economy makes the system unworkable), and having both been in favour of it to begin with (or in the case of St. Petersburg, in the principle of insurance only), the trade unions representing the broad class of workers in the healthcare industry in the two sites have pursued different paths. While Volgograd seems to have

maintained more of the traditional Soviet role of the trade union as corporate manager of workers' interests, in St. Petersburg (and Leningrad Oblast – the union has covered both territories since before they were divided under the post-independence constitutional settlement) has sought a more pluralist approach and as a result at times has risked expulsion and alienation. These developments are partly conditioned by circumstance, but also by leadership choices.

In general contradistinction to their Western counterparts, in effect Soviet trade unions represented the state (the employer) to the workers, ensuring worker discipline and administering work-place benefits. Indeed they were commonly described as "transmission belts" from the top downwards, no more or less than "the personnel and social welfare departments" of any organisation (Ashwin, 1995: 194). Unlike Western unions, managers of factories and even the state ministers responsible for that branch of the economy would be members. Although the institutional structure might portray the unions as involved in a very close-knit form of corporatism, none of these benefits that they administered (such as the management of additional pay schemes for long, hard or intensive work, children's holiday camps, social (sickness) insurance, child benefits and other entitlements) nor the rights to veto any dismissal existed as a result of struggle and historical compromise between unions and employers. Unions were effectively part of the management structure, and through the system of branch and territorial committees and through its (naturally subservient) relationship with Communist Party structures, they formed part of the vertikal' of the command-administrative system. It was their role to execute policy rather than to inform it.

Furthermore, trade unions were imposed as organisations over sectors, rather than arising out of organic mutual interest. In the case of health care, *all* employees of the health care sector were put into the same union – the union of medical workers. According to Field, this occurred in the 1920s as a means to undermine those doctors associations that had developed in opposition to government policy, strengthening and encouraging the paramedics' union to expand to all medical personnel. This both humiliated the doctors by undercutting their supposed expertise-based superiority (in line with various "anti-bourgeois" strategies pursued by the early Stalin regime), and by removing them as a possible separate voice. As a result "the profession as an independent corporate group was eliminated from the Soviet scene early in the history of the regime' (Field, 1991: 84). Ryan (1978) argues that this blurring of the distinction between doctors and other personnel was furthered by encouraging paramedics to train up to be doctors after a few years work. Thus in health care, there was a clear policy working against the natural tendency of doctors to organise amongst themselves.

The extent to which trade unions *per se* in the Soviet Union could garner support from their members (after all, they did provide benefits and enforce laws that made sacking workers very difficult) is of course hard to assess. Behavioural studies in totalitarian regimes are deeply problematic, as the most immediate means of social control are not visible, despite their strength (see, for example, Havel (1987) for an articulate expression of the problem). Much of what is available from the time therefore is only negative – as all positive material concerning loyalty must be treated with suspicion. However, research subsequent to the collapse of the Soviet Union tends to confirm the problems unions had – and continue to have. According to Rutland, "in practice, the workers were indifferent to or alienated from these structures seeing them as integral parts of the ruling party-state apparatus". (1991: 289). Furthermore, this alienation deepened over the period of Brezhnevite stagnation, as officials and institutions became less responsive (Hauslohner 1991:39). Although one can overdo the extent to which they generated active resentment, it certainly seems true that they arrived in the 1980s as organisations that across the economy were weak in terms of their influence on policy direction, and whose involvement in welfare provision did little to curb the distance and alienation of their members.

Unions under Perestroika and Glasnost'

During *Perestroika* unions were among the first social organisations to respond (or to be made to respond) to the increased drive for pluralism and openness within society. In 1987 the All-Union Central Council of Trade Unions declared its independence from both party and state, although this declaration allowed the movement to take up a generally more conservative anti-*Perestroika* position, ironically seeking to support the incumbent interests of the party with which it had formally cut ties (Clarke, 1997). The move to greater independence was arguably cosmetic in the short term in the case of the healthcare unions, who were still responsible for management of the workers and administration of state-sanctioned benefits. In 1987 *Meditsinskaya Gazeta* published "material for discussion" towards the second plenum of the central committee of the medical workers trade union under the legend "The criterion of *Perestroika* is action", including the following suggestion:

> The 18th Trade Union congress of the USSR paid great attention to health protection of the population of the country. It demanded from the trade union of medical workers and the healthcare administration stronger attention towards the organisation of the advantageous medical care for the workers in industrial enterprises and in agriculture, the realisation of the complex programme "Health" [zdorov'e] and on this basis the lowering of the level of temporary incapacity at work...We must, with the ministries and departments achieve the

> construction of medical stations [*mediko-sanitarnye chasti*], prophylactic-sanatoria, and other curative institutions in the large industrial enterprises, the betterment of the situation of assessment of temporary incapacity. (MG 8.5.87/2).

Thus, although the trade unions were officially adapting to the more pluralist environment encouraged by the Gorbachev era, they were also subject to the exhortative method of social development used at the time – the attempted mobilisation of the presumed socialist will of all categories of citizens to make a better society. Indeed, the trade unions were being handed even greater responsibilities in the administration of social benefits and the solution of the needs of the workers. This, however, represented not so much their empowerment, but increasing their involvement in the command-distributive system. In fact, their ability to "rely on the collectives and on the opinions of the workers" in solving social problems, and in "the legal defence of their interests" was noted as being "weak" in the same document (MG8.5.87/1). That is, these institutions were not adapted to acting on the wishes of their members. Strengthening their control over resources if anything may have served to increase resentment.

This increased role in social policy exposed trade unions to attack once the *perestroika*-era economy began seriously to falter. In 1989 a law was proposed that increased the role of the unions across the economy. However already there were stresses in the system of distribution. A member of the Krasnodar union committee wrote to Meditsinskaya Gazeta:

> It is customary to say: 'Our healthcare is poor; the pay is inadequate considering our efforts. But it's not even the case that health care is 100% funded even by current norms. The money for pay, economic and other needs isn't given to the funds, even specifically targeted funds. For example, the ministry of health of the RSFSR gave for the development of sanitorium transport in Krasnodar *Krai* 1 million 300 thousand roubles. On the financial board of the executive committee of the *Krai* the money was distributed in its own way and healthcare missed out on half a million roubles. (MG 16.6.89/2)

That is, trade unions were being asked to take on even more responsibility just at the time that the system was disintegrating. One union committee chair from Khabarovsk saw such proposals as attempts to strengthen the role of the unions as "lackeys" (*na podkhvate*) of the administration (MG 12.5.89/2). However, the majority were happy to increase their role as, for example "yet one more important step in the path to the creation of a legitimate state [through] widening and strengthening the rights of trade unions in the resolution of the most

important questions of economic and social life of the country." (MG 19.5.89) – certainly the union itself saw it as part of the process of "deepening democracy, strengthening the economic independence of the unions, strengthening their role in active social policy and in the situation in work collectives" (MG 12.5.89/1). At the same time that more and more members of the unions were dissatisfied with their work, their leaders appeared more and more convinced of their role. In the two sites of this study, this conviction appears to have been genuine.

The trade unions, embedded in the distributive system, effectively the administrators of state welfare and with a vested interest in achieving discipline at work, were unable effectively to respond to the demands of medical workers from 1990 onwards as the funding for healthcare as in all sections of the economy started to shrink (administrators fondly talked of the years 1985-7 as being the peak years for municipal funding). Their inability to detail policy demands upwards effectively was reflected in the growth of any number of associations of doctors also claiming to represent the interests at least of the more qualified staff – more of which later. Their higher membership was also split between opposition to *Perestroika* and those who saw the new openness as a means to re-position themselves.

In 1990-91 as the economic situation worsened, strike committees [*stachkom*] formed to monitor the situation in health care, to establish whether industrial action should be taken. The trade unions were commonly excluded or sidelined, as part of the system against which the stachkom might call a strike. In the pages of Meditsinskaya Gazeta in those years the evidence clearly suggests a degree of disillusionment with the trade unions.

St. Petersburg and Volgograd: Anglo-Saxon dualism and Soviet corporatism.

The head of the St. Petersburg/Leningrad Oblast' trade union Vladimir Dmitriev recalls the hostility with which he was met in trying to persuade the stachkom to work with the trade unions:

> Until recently, from 1990, 1991, the trade union went through a difficult period. We were called the Oblast' committee, but after new legislation, we covered two federal subjects, it was very difficult for the trade union, in respect of the unhappy situation of medics in 1991. They organised conferences, there was a city Stachkom. At the conferences, they wouldn't give me the floor to explain the position of the union, accusing the union – and myself personally – that we weren't asserting the rights and demands of healthcare workers.

When asked if these accusations were justified:

I think (sighs) there *were* grounds. The forms of rights-defence can vary. We had gone down the traditional route of turning with our problems to the central committee, to the ministry of health, but here we didn't take on other forms, well, the ones traditionally essential to trade unions: picketing, street demonstrations [manifestatsii], ultimately, the threat of strikes.

- You didn't take such steps?

No, we didn't.

- But others wanted you to?

Yes, others, the stachkom wanted the trade union to, with observers, *etc.* There was a wave of "strike movements". Not strikes, but "strikedness" (statechnoe [dvizhenie]), and they urged the trade union and myself personally onto more active measures. Therefore we started to widen our arsenal, our methods, we organised pickets, we tried to get to all structures where questions of healthcare are decided.

These "traditional" methods of protest – of addressing the various higher-level administrative organs were common to many of the early attempts by trade unions to protest, and typical of an organisation which at a certain level identified itself with the administration of the system. Even as late as 1993 it was reported at a conference organised by the St. Petersburg sanitary-epidemic medical workers union that "in spite of the admonishment of the local representatives of the union of healthcare workers...the delegates at the conference practically unanimously decided to go to extreme measures" (MG 27.8.93/5). By 1994 Dmitriev in *Meditsinskaya Gazeta* conceded that strikes were an "important weapon in the arsenal" (MG 23.11.94).

Significantly, the Volgograd medical workers union has apparently not abandoned traditional methods at all:

- How would you rate the level of influence of your organisation?

The level of influence...what's most important is the result, what the result is. Although we wouldn't praise ourselves it seemed to us, it isn't that bad. We've got pay on time... It's another question, which is complex, is what more we can do. There is industrial action we've undertaken. There are agreements with the ministry, with the Oblast' committee about the defence of the rights of medical workers. *Stachki, zabastovki* [strikes], appeals to the procurator what was done and why, to bring the attention of leaders to the conditions in healthcare and of our health workers. They see the problems, they see healthcare, but it isn't the case that they don't want to do anything. There isn't the possibility to make the situation better. And so our influence, looking at the results, the influence is not bad.

- What do other organisations think of you?

> With respect. In order to have normal relations, we need to be competent, and we try to get this. That's the most important. You need to know the healthcare system in order to reckon with us. So initiatives [predpriyatiya] we all take together. In terms of development, in terms of health care, work matters with regard to pay, all recommendations that come from us they get. We train people together – that's also important, we are also consulted on many issues, we are party to official agreements. So here our influence is taken into consideration.

That is, they see their role mainly as communicating problems to the administration – what one correspondent to *Meditsinskaya Gazeta* called "having our interests represented but not defended". Their focus is on competence in fulfilling specified tasks. The union seems to consider influence in a formal sense, legalistic sense, rather than as a matter of concrete impact on policy. It does possess (as does the Petersburg union) a formal role as a signatory to many general agreements – on tariffs, for example, as well as on pay and conditions. But this legalism suggests that formal participation is an end in itself. Those who are in opposition to the Oblast' handling of health financing see them as, bluntly, a waste of time, having "no influence at all", if not somewhat obstructive. Of course, the union respondents may not have wished to reveal the real nature of conflicts, but their positive descriptions of their work fit precisely into that model of a union that is an adjunct of the administration. Although they claim to have been involved in strike action, at the time of the interviews, they appeared to be frustrating the attempts by the city to increase budget funding for healthcare from the Oblast'.

The faith of the Volgograd Oblast' union in their methods led them to prioritise the resurrection of the *vertikal'*.

> The trade union believes that in the creation of this system the vertikal' is broken. [With the *vertikal'*] the ministry directly influences the committee, the committee influences the *raion*, *etc.* and right to the *feldsher* (paramedic) point. But with the law on local self-government, the head of the administration can fulfil this law in his own way.

For without the vertikal', where persuasion of individuals higher up the chain might bring change, direct political (rather than bureaucratic) pressure *has to be used* where conflict exists between actors in order to achieve objectives.

While partly this is a result of ideological inertia – in St. Petersburg Dmitriev said he had to play a waiting game while some in the trade union and others that dealt with it realised the importance of mass movements – there are also other factors that inhibit trade unions from

detaching themselves from the administration to become an oppositional force, what Dmitriev called (in distinction to "German social partnership") the "English" "conflictual" mode. Firstly it has a diverse membership. The interests and motivations of doctors, paramedics, nurses, ambulance drivers and others are often at variance, as well as different priorities in how they should be expressed. While the *stachkomy* in all the regions of Russia were admonishing the unions for not defending their interest strongly enough, the various associations of doctors that were springing up were declaring that it was not the place of their members to risk the lives of their patients by striking. Furthermore, by comparison with the platforms of these medical associations, the unions appeared not to be able to focus on more specific demands and proposals, distracted by the greater urgency given to the problems that united a diverse membership – budget and insurance funding per se, and economic reform.

Secondly, although membership that stretches up the administrative/executive vertikal' inclines the union not to approach conflict effectively within its own ranks, there are reasons for not wishing to jettison those upper layers for the sake of more focussed action. Il'in (1995) points out that in many branches of the economy, the fundamental problem is not within the branch itself, but with the treatment of it by central government. It therefore pays to have some expression of unity on behalf of the whole sector that voices overall problems of funding. To repeat: all the respondents in this study named the economic situation and under-funding as the two greatest problems facing healthcare and the insurance system. These resulted not from disputes within the sector, but between the sector – including the ministry of health – and the central treasury and local treasuries. Therefore it is a likely strategic choice to keep broad support to focus on Moran's third aim of wresting resources from society. Under conditions of slowly haemorrhaging membership, there is an incentive not to rock the boat internally, to pursue a more cautious, less confrontational strategy. Paradoxically, it has even been suggested that one of the main interested parties in strikes are actually the local administrations against whom strikes might be aimed – seeking to show the centre the problems they have with their own workers.

Thirdly, has been an ideological movement away from trade unions, and certainly those who had been part of the Soviet system. Although the Yel'tsin government from the beginning had spoken of German-style social partnership, and the formal inclusion of trade unions into many decision-making processes occurred throughout Russia, this appears to have been a cosmetic arrangement. In the words of the head of the St. Petersburg union:

> If one speaks of the development social partnership on the federal level, we, the trade unions idealised this system of partnership right at the beginning of its development, we thought that this path of negotiations – trade unions, unions of manufacturers, businessmen, the employers, and the government of Russia, we could solve a series of social problems. Unfortunately, this didn't happen, it didn't happen under Chernomyrdin, under Kirienko.

Peregudov (2001) argues that tripartite corporatism is simply an aspiration, undermined by both neo-liberals who would rather have entirely free contractual relationships, and state planners who would rather impose 'rational' policy. The over-representation of oligarchical business interests in Russian politics does not help either. That the unions, one of the central actors in social policy provision previously – were not involved in the model of medical insurance enacted (insurance being dealt with by employers) could thus be seen as not merely symptomatic of the general rush away from the Soviet model of welfare remarked upon in Chapters 4 and 5, but also as produced by the two dominant and opposing discourses having no place for them. In the pages of Meditsinskaya Gazeta in the early 1990s (following the wave of strikes in 1990 and 1991) there is very little mention of union activity at all – a fact gently alluded to by Dmitriev in 1994 (MG 23 11 94).

Fourthly, unions face legal and financial difficulties in employing industrial action. There is a legal obligation to maintain certain minimum standards of care for a strike to be legal. Furthermore head doctors need to let their workers go to any demonstration. However, commonly they are both against strikes on ethical grounds, and part of the management structures against which unions may be protesting. The unions also have difficulty in mobilising people – there is little the union can offer when its access to social services and other support for its members is limited by financing (which is meagre) and by law. As one of the demonstrators on the march on 7 November 1999 commented:

> Why is our trade union so weak? We had a fund, a strike fund. No more. To declare a strike and support people financially – we just can't do it... I think [if there was a strike declared today] no one would come out – from purely material reasons. The union cannot help materially, it doesn't have that possibility. If one were to give it a higher percentage [from the wage fund]...

Lastly, the unions were still dependent upon the administration and other employers for their survival. In an environment where radical political changes do not inspire the same nervousness as in calmer times, making life difficult for those who effectively control your financing is unwise, especially where, as remarked upon in the previous chapter, the

distinction between personal and political relationships is not particularly clear. As documented in the history of the insurance system in St. Petersburg, the original innovator, the ex-chair of healthcare Valerii Koryukin, was removed partly at the instigation of the unions after he had attempted both to exclude them from healthcare institutions and sought to find them and Dmitriev personally guilty of the abuse of union funds. He was removed only with the election of a new governor who had struck a deal with the unions in return for their support. In Nizhniy Novgorod the health union chair, continues in a similar vein:

> I haven't even mentioned the illegal attempts to forbid the deduction of contributions to the union by accounting departments, the eviction of the trade unions from the governance of the social insurance funds, the legislative limitation of their rights. (MG 15.6.94/7)

Thus following the path of confrontation can prove costly for unions. However, following the path of administrative co-operation can also lead to irrelevance. In St. Petersburg although the union was seen by many administrators as an irritant (but by others, for example the insurance company representatives, as simply doing its job), it had obviously made some progress. According to Dmitriev,

> In 1991 there was the last meeting of the strike committee, in this meeting it was said, that in principle the stachkom understood that the union had taken up a correct position, that it actively defended rights, and the stachkom handed the responsibilities of solving problems in healthcare to the trade union.

The trade union in Volgograd was barely seen as relevant by anyone – except the union themselves. When asked about their influence, twice the answer was simply "*nikakoe*" – none whatsoever. Some, as evidenced by the quotation from the Volgograd City Health Care committee, saw them as even mildly obstructive in their inertia. They had organised some strikes, but these were few and far between. In interview they were very keen to emphasise the willingness of the Oblast authorities to help; strikes were for symbolic communication rather than to achieve a result directly. Assessing the relative effectiveness of these strategies is, of course difficult. In the absence of open conflict on public record it is difficult to examine the effectiveness of the Volgograd Oblast union. However, given that the single achievement they mentioned in the interview was making sure that pay arrived on time (which tends in Russia to be an Oblast'-wide problem of cash-flows and governance rather than a sectoral one) compared to the St. Petersburg union's strong influence in the removal of Koryukin (having survived his attempt to ban them from the work place), the defence of

holiday entitlements in the health sector as well as having some influence in bringing Sobchak's attention to non-payment of contributions by the municipalities in 1996, it does seem that the policy of maintaining formal Soviet corporatism in Volgograd Oblast' is less productive. One may see further evidence for frustration with this policy by the hope some respondents placed in the Association of Doctors, even though, as we see below, the Association is barely off the ground. Meanwhile in Petersburg, membership of the union has started to rise again.

Attitudes to the medical insurance system

Both unions have a similar approach to the introduction of medical insurance: they supported it in principle when it first arrived because it provided (in theory) additional funding, but have become disillusioned. However there are two contrasts to be drawn. First of all the Volgograd trade union is more in favour of the model as it was supposed to work according to law, and detailed its advantages:

> Well, the most important thing was that it was additional funding, that allowed health care to live better. The second good point was that this system gave the chance to improve quality and for doctors to answer for their work and the work of LPU in front of the patient – for quality – a fight [*bor'ba*] for quality. So if you work well, the ill will come to you, you will get more. Third: it allowed the patient to choose the institution – you could show your policy and get treatment. This was good, because if I don't like this doctor, I can go to another one. [...] And so these are the basic positive elements of compulsory medical insurance. And doctors were ready for this system to work well.

In contrast in St. Petersburg there was a general acceptance of the idea of health insurance, rather than either the model that was proposed or the one that was enacted:

> Regarding the law itself: it was a possibility to increase expenditures by taking money from companies, just as it happens in the West, with the rich paying for the poor and the healthy paying for the sick. Unfortunately in Russia as is so common, things have been taken to the absurd.

The Volgograd union's opposition to the system was based not on the system itself, but on the peculiar conditions of the time making the model inappropriate:

> It would have been fine had there been more money, but there was less money in the budget at the oblast level. It was linked to the fact that industry fell, the budget got less and less and less and to get additional allocations, to compulsory medical insurance they were no longer additional, but the main funding. This is very serious, every year there's attempts to cut back... So at a certain point it [the compulsory insurance system] changed from being additional to being the main source of funds. And this small infant became the main budget for healthcare. And so the positive elements of CMI now no longer work.
>
> But with the law on local self-government, the head of the administration can fulfil this law in his own way [*svoeobrazno*]. He deals with the budget, and the budget varies everywhere. In one place it can be 20% in the Oblast', but in Volzhskii it can be 8%. It's very little for health care, you see. And it was very difficult to prove to those institutions. And that's evidence, that the *vertikal'* doesn't really work. The law is enacted in different ways. And it's difficult for healthcare to work without this *vertikal'*.
>
> This is another reflection of the law on self-government. It depends not on politics, but on personality. If the head of the *raion* understands the importance of health care for the workers, then health care will be attended to. And in other places, there are other problems that are of more immediate attention.

In St. Petersburg Dmitriev had apparently also used the word "absurd" in a speech that led to the trade union committee passing a motion of no confidence in Koryukin. As with other respondents he accepted the fact of the market, calling it a "reality" with which no one could argue. However, he understood the insurance system as part of the general transformation of the Russian economy and polity under Yel'tsin that, in his view, has led to no kind of improvement – the economy is unstable, the budget is smaller and more unstable and so forth. He also appeared to blame the insurance system for under-funding: it had rationalised spending, leading to, amongst other things: a lack of provision for some expensive operations; the absence of food provision for many patients; and a diminished territorial programme. He was far less forthcoming about any benefits specifically of health insurance. One may indeed see this as an example of the 'global' conception of transition that many on either side of the debate put forward. Dmitriev's opposition was ultimately based upon opposition to market reform *in general*, despite its apparent inevitability.

For the Volgograd Oblast' union, the insurance system was the only source of funding keeping the system going; but insurance companies were simply unable to operate if not inappropriate in the current economic climate. Indeed in the interview there was a small lament for them. Many of the problems were operational – how to index medical prices

properly, how to make sure there aren't too many insurance companies that make the system hard to monitor and so forth. By contrast, for Dmitriev the system itself creates these problems, albeit in circumstances of economic depression: the "most expensive model of health insurance" [*samaya zatratnaya model'*] a "mass of bureaucrats" in the fund, expensive intermediaries in the form of insurance companies which speculated on the money they receive, while having little experience or ability in their analytical functions. While many others were more inclined to regard any such defects as teething problems, he would rather have seen the companies abandoned and the fund take over their role as insurers, with the doctors defending the rights of the patients.

The second difference between the two unions is who shares these views. The St. Petersburg Trade union is nearly unique in its general opposition to the system; only one administrative head is outright opposed to it, but that he attributes to his own ideological inertia. The Volgograd union appears to be more supportive of the specific system in a region where general opposition to the system is much stronger on the part of the city and some observers and administrative heads – where the idea of Fund-free or insurance-company-free social medical insurance is more popular. This difference seems to me to reflect the difference in approaches to their work – the Petersburg union reflects the disquiet expressed by rank and file medical personnel at compulsory medical insurance, expressed both in the pages of Meditsinskaya Gazeta, and asserted by Dmitriev. Meanwhile the Volgograd union reflects the general tendency of regional administrations to support it.

Medical Associations

The moves towards creating the association started with the introduction of medical insurance, and when the insurance companies united.

Executive director of the St. Petersburg Medical Association

"It only exists on paper. I've perceived no action on their part"

Head of a *raion*, Volgograd

The various federal and local medical associations that have sprung up in Russia over the past ten years have exemplified the problem of interest representation in Soviet and Post-Soviet health care. As argued above, the trade union has not achieved, nor was it earlier meant to achieve this. Traditionally "representing" the interests of all who work in health care institutions – from the surgeons to the ambulance drivers, the union agenda was so broad as to swamp issues specific to doctors. Essentially they represented the management to the workers, disciplining them and organising them. Conversely, there has been no tradition

of medical oversight, and an apparently authoritarian and unpredictable attitude taken towards errors of professional judgement that, many doctors claim, has deprived them of responsibility for their work through excessive administrative control. The hierarchical nature of the medical profession, and the deliberate absence of a clear division between healthcare administrators and medical practitioners (*all* of the former have risen out of the latter), as well as various state attempts to "de-professionalise" the medical profession (referred to in the introduction to this chapter) appears to make representation upwards within the health service problematic. In sum, the medical profession has been deprived not only of representation, but of autonomy and professional responsibility.

The introduction of medical insurance has provided a partial solution to this problem, with quality assessment and financing partly removed from this hierarchy and put into the hands of the insurance companies. There is a new distinction between purchasers and providers, allowing a clearer identity as practising doctors to develop. With the organisation of opposing interests, it also makes political sense. The advent of pluralism appears to be the dominant explanation for why the association in St. Petersburg appears to have embedded itself more soundly in the system, and why in Volgograd, with the insurance system in retreat, their association (in truth simply a division of a Russia-wide organisation) is largely inactive. The method of association – a confederate approach taking in the various specialist associations – has allowed the St. Petersburg Association to strengthens its focus upon professional matters. Thus the natural conflict that might emerge between association and trade union – which is charged with and installed as pursuing questions of labour conditions – is more or less successfully eliminated. As a corporate body, it can also fulfil the function of mediating, developing a distinctive voice for the policy-making process.

Medical Associations in Post-Soviet Russia

On 10 February 1989 on the front page of *Meditsinskaya Gazeta* – at that time still under the aegis of the Ministry of Health and the Central Committee of the Trade Union – there appeared an article entitled "Association of Doctors: the time has come", containing a suggestion by a Moscow-based doctor that it was appropriate now for doctors to organise themselves in defence of their interests. He claimed that doctors were disunited and separated, that the command-administrative system of health care had removed the moral and practical independence of doctors yet punished them without due process or redress, and that the doctors' voice in the restructuring of health care and society had simply not been heard. The various aims of the association, or union (he used the words interchangeably) could be to help co-ordinate health care in the localities; as well as offer legal protection to

its members, govern the licensing of doctors, organise assistance to the poor, sponsor study abroad and so forth.

The article provoked a year-long debate under the same legend. It was catalysed by the publication of a provisional constitution written by a working party made up of various head doctors and administrators, as well as the trade union central committee chairman. The discussion reveals a good deal about the poor situation that doctors felt they were in. The majority of published letters supported the establishment of the association in general, but many had reservations. Chief among these was the frequent demand that no one involved in the organisation of health care – even head doctors and their deputies – be allowed membership, with some extending that criterion to some who were actually practising medicine. The organisation, it was commonly argued, should be democratic and independent of the state, and decentralised. The association should perform the accreditation and oversight of doctors, on the grounds that only they understand their work (and some suggested part of this was raising the moral awareness of "enslaved" Soviet-born practitioners). More generally there was the feeling that doctors were "without protection", both legally and financially. Under "protection" [*zashchita*] was understood both pay and conditions at work, and questions of professional practice.

In short, the diagnosis for all the malaise suffered by doctors in the Soviet health system was that practising doctors did not have enough control and autonomy over their own work, and that the management of health care had ridden roughshod over their rights. In general, people seemed to be saying, society didn't understand healthcare. The solution was simple – wrest control and influence over the affairs of doctors from the hands of "others".

However, such approaches at that time were problematic – quite apart from the paradox of creating another institution run by doctors to solve the sins of the contemporary doctor-run system. The experience of a group of doctors in Vladimir, whose attempt to organise their own local association in the city was banned by the city executive committee, showed the difficulty of acting without the co-operation and involvement of those higher up the chain of command. They had relied upon article 51 of the 1977 Soviet constitution to guarantee them freedom of association. In fact, the article guaranteed the right to participate in any organisation that defended the member's interests, not create new organisations. As their proposed constitution had contained powers already entrusted either to the *ispolkom* (executive committee), or the trade union, there were no grounds, so ran the judgement, for allowing them to do so.

The activities of a medical association in most countries comprise both representation in broad health care policy-making and working conditions for doctors (as

was the business of the trade union) and providing a forum for the discussion of more specific medical matters, which might indeed impact upon health care organisation in terms of "rational practice". However, in Russia there have always been more specialised associations, which dealt with particular branches of medicine and their relation to the broader system – removing much of the need for a general association to cover these matters. Furthermore, according to Ryan (1978) the Soviet tendency to intensified medical specialisation gave rise to "compartmentalised" practice and knowledge. It is fair to speculate that this specialisation and differentiation within the profession interacted with the tendency to use specialised knowledge to define one's group, and thus was reflected in views of how broad (or limited) common interests are or should be.

Furthermore, at the time it would have been difficult to exercise influence in what was formally a corporate system of decision-making while simultaneously alienating those who had control. The consent (which effectively meant the encouragement) of the head doctors, the trade unions, the ministry and so forth was necessary. That there may not have been the fertile ground for mobilising the medical profession against its own organisers is also a factor: in a hierarchical profession with no apparent social barrier to upward mobility raising consciousness of any need to mobilise on a large scale against one's superiors is problematic.

In sum, as the head of health care in Volzhskii commented: "Doctors themselves don't understand the need to unite".

It is perhaps not surprising that in the "initiative group" which drew up the constitutional proposals for the association there were numerous "specialists" from each of the republican ministries, as well as several head doctors and the chair of the central trade union. Even though there appeared to be a good deal of support for the development of grass-roots organisations, the decision was taken on a union-wide scale.

In July 1990 the USSR Medical Association was formed. In October 1990 there took place the founding congress of the Association of Doctors of Russia in Ryazan'. According to *Meditsinskaya Gazeta*, the congress started in a stormy fashion, with the honorary presidium of the head of the new USSR Medical Association being rejected. The debates regarding whether the association should have an administrative role, how it should go about the introduction of insurance medicine (already seen as the "salvation" of health care), whether it should have a merely campaigning role and so forth. The president of the association saw its role as covering the horizontal exchange of information, the development of healthcare policy and economic mechanisms for its improvement. Another member of the

council saw it as "a defence against the new bureaucrats". Meditsinskaya Gazeta was moved to write at the head of an interview with the vice-chairman of the Supreme Soviet health care committee:

> People don't just talk about medical associations. They are also being created, in spite of the absence of adequate legal bases, the lack of clarity regarding what they should do and what relations there should be with the legislative, executive, representative and other branches of power. (MG 25.9.92)

This lack of clarity seemed to remove the possibility that the association itself would make much headway. Indeed, as a national organisation it appears to have had little or no input into policy at the centre over the early 1990s, although they are often mentioned in lists of social organisations. The same is true for the "Interregional Medical Association" whose officers are mentioned and occasionally published over this same period of time, and whose tasks are similar to the Association of Doctors – the defence of doctors' interests, the right to accredit and conduct peer-oversight and so forth. Indeed, the representational aspect of these associations seems to have been ineffective judging by the correspondence to the paper. Every two years or so there are all-Russian congresses of doctors, named "Pirogov congresses" after the eminent Russian physician, where for three days or so doctors can air their grievances. These conferences were and are actually organised by a congress committee composed of the trade unions and other social organisations under the aegis of the "Russian Medical Association", an organisation dedicated more vaguely to "the solution of vital tasks in the healthcare sphere, medical science and education" (*Constitution of the Russian Medical Association*, article 2.1), rather than to the specific defence and organisation of doctors. The announcement of each congress has been followed by various correspondence from association representatives lending their support to the gathering. This suggests that the association 'movement', which has had aspirations of uniting doctors, appears to be yet another series of pressure groups spread across the same population with similar aims, and whose membership at the top of the organisation appears interchangeable.

At the same time as there were attempts to unite doctors across Russia, there were "associations of medical workers" growing in the localities, although again as part of a federal-wide initiative. By the middle of 1994 it was claimed that there were such associations in all regions of Russia. Many of them had the specific aim of not duplicating the work of the trade unions – separating what were considered professional questions (solution of conflicts inside collectives, developing the status of medical workers, seeking to insure doctors against professional mistakes) from what the head of the Petersburg association called "purely social questions". In St. Petersburg the association gained 20%

representation on the licensing and accreditation committee, despite covering only 14% of its possible membership (MG 22.6.94/2).

However, such organisations were obviously ineffective in meeting their aims. The 1995 Pirogov congress resolution contained the following paragraph:

> All these [problems – weakness of central power, the collapse in population health, the poverty amongst doctors and other medical workers] are a reason for raising the social and professional responsibility of health care workers, most of all doctors, and are a motivation for them to unite both in scientific organisations and in professional medical associations…(MG 8.12.95)

That is, despite all the various attempts to unite there was still felt to be missing a representative organisation adequately working to improve the professional working conditions of doctors.

St. Petersburg and Volgograd: A Talking Shop vs. Failed Corporatism (Again)

The Medical Association of St. Petersburg, founded in June 1996, has apparently flourished, whereas the Volgograd department of the supposedly re-invigorated Russian Association of Doctors is dismissed by respondents as "inert" and ineffective. I believe the key to this success is in the context of their existence, the nature of the membership, and the policy-system each inhabits.

As cited above, the executive director identifies the key moment determining the formation of the association in St. Petersburg – the onset of insurance medicine and the development of organisations separate from the normal health care structures. This, he says, created an environment where the trade union was no longer appropriate by itself. One of the key determinants of working conditions becomes the method of payment for health care – whether per service rendered, per diem, or per diagnostic group. However, the choice of such methods is not an appropriate matter for the trade union, as it steps into questions of medical practice rather than simple labour practice – although matters of the increase in paperwork are the matter of both. Furthermore, the clearer governing structures in St. Petersburg allowed for more focussed discussion of such policy choices. The *raiony* and the city have more coherent bargaining power as insurance commissioners; the insurance companies, themselves in an embryonic association are all in stable health, living off large municipal contracts, competing within a stable insurance field, and in co-operation with the territorial

fund. The fund itself, according to the head of the Petersburg Association, is "alienated from the medical profession". It is therefore natural as these actor-groupings coalesce that greater focus is given to unity of the medical profession.

In Volgograd, there is no clear focus for debate, as the city is at odds with the Oblast', the territorial fund seeks to by pass the insurance companies, and the *raion*y can only attempt proper influence on payment methods through their governance of institutions rather than as insurants as well. Furthermore, the policy-making processes at various levels appear less pluralist and more *faux*-corporate, with formal interest representation, but little support. Although the association officially has representation on the governing board of the fund and on the Oblast' committee, these institutions appear to exercise little control over the Territorial fund. Interestingly, the head of the Volgograd association supported a temporary return to full state funding, reinforcing the situation in the early 1990s and before, where the boundaries between authority and mobilised association members was so unclear as to undermine that mobilisation. There is therefore little distinction between *raion* health committees and the medics they employ, and conflict between purchasers of insurance medicine. What role could an association fill in such a situation?

Secondly, the membership of the St. Petersburg association is predominantly corporate. It is comprised of most of the specialist associations of the city as well the committees of head doctors and health managers, as well as the association of insurance companies. Although this might appear to contradict its officially stated aim of "the defence of the rights and interests of its members" (statute 1.1)[2] by which it certainly means individuals, by uniting the specialist associations it is made easier for the association to focus upon these more "professional" issues, leaving the trade union (itself a corporate member) to deal with more prosaic pay and conditions matters.

Indeed, there is a paradox in the difference between the trade union and the association. While Dmitriev seeks to emphasise the union's individual membership over the association's "collective membership", the executive director of the Association Yurii Korzhaev emphasises the "collective organisation" of the trade union – which operates in terms of mass participation. While both offer support to individuals (the association offers legal and professional insurance) in disputes, the heads of both the union and the Association are adamant that their roles are distinct, albeit occasionally overlapping. While in Volgograd the clear distinction between the role of the union and the role of any association is similarly

[2] Other tasks include raising the level of professional education, the development of a single coherent policy in health care and in the activity of health care workers, to act to raise the quality and accessibility of medical help and of social and professional defence of medical workers". This is in

distinguished by respondents, there is no structural device to reinforce this difference. It becomes difficult to unbundle the social and professional questions (the trade union leaders saw their "social" focus as being "wider" rather than different to the "professional" focus of the association). There is the further problem that the association itself was formed as the regional section of a Russia-wide organisation, rather than a response to demands from local doctors. Attempts to organise local associations in Volzhskii and elsewhere in the Oblast' have apparently failed.

Indeed, corporate membership, as well as having the various advantages of evolving locally, and thereby more likely adapted to local conditions, also overcomes the problems related to above of seeking to cover ground already occupied by existing groups. In seeking to express the views of the various specialist associations collectively, it runs less of the risk of being superfluous and additional, and has less of a task in justifying itself. By contrast, the Volgograd Association, being ultimately a branch of a national association, does not present itself immediately as necessary (except as the promise of 'something better'). It has no institutional basis for being different from the trade union, nor is it structured to aid the expression of local views.

The third difference is that although the St. Petersburg association was charged with defending the professional interests of medics, the "essence" of the association, according to Korzhaev, is to "unite all the [specialist] associations and social medical organisations before power" – *i.e.* to provide a forum for debate and communication. It did not seek primarily to represent the interests of doctors to authority, but to seek contact and discussion between different elements of the health care system in order better to express the preferences of medics within the health care system. The head of one large St. Petersburg *raion* stated his liking for the association as it gave the *raion* heads the chance to "put certain questions to the governor, the committee, the fund and in this way exercise influence". Another described the association as "powerful. It can discuss and recommend to the powers that be." The association produces the local medical newspaper *Meditsina Peterburga*, which respondents felt was a neutral and accessible publication, and whose aim is to "raise awareness of issues in healthcare in the city". The head of the trade union used the association to plead with head doctors to release members for strike action and demonstrations. In short, it provides a forum for various policy actors to talk to each other. Thus the one striking dissenting voice regarding the association, head of the first insurance company in St. Petersburg seems to miss the point (as well as apparently underestimate) when he questions how the association

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essence no different to any other proposed constitution for any other form of medical or doctors' association.

could be influential, repeating the charge that was often levelled at the Volgograd Association – that it was "only on paper". It achieves co-ordination of the profession, and mediates conflict. On many issues its role is not to influence, but to convey.

In maintaining the notion of representation of doctors' professional interests as the dominant function of any association (the typical understanding of the association), Volgograd Oblast' is prey to the obstacles which beset the formation of such organisations across Russia in the 1990s. Furthermore, the head of the Volgograd association appeared not to consider his role significant, not least compared with his rectorship of the medical academy. He appears to have been appointed for his eminence rather than his advocacy. His opinions on the health insurance system seem firmly to be that of the holistic academic – constantly returning to the problems of economics, the influence of foreign countries over political matters and the nature of free health care *per se* – suggesting little activity in his role of association head.

The Division between professional and social issues

The division between the trade union role of defending conditions at work, and associations having as their remit the discussion of "professional" matters appears unsustainable, and could serve to undermine the medical profession. In particular, by delineating their roles, both organisations remove the blanket right to have an opinion on *any* matter in health care that could impact on their members. A good example is the method of payment for services. This is neither a matter *in principle* of work and conditions, nor can it easily be related to methods of treatment, except where it may affect certain treatments (charges for medicines in the Soviet Union, for example, were traditionally not applied for treatment for certain communicable social diseases such as syphilis, TB and dysentery in order to make sure treatment is undertaken). However, with regard to informal charging it affects doctors in terms of conditions at work – the stress placed upon them assessing who can and cannot pay and how much.

Indeed, in St. Petersburg the refusal of the union to involve itself directly in certain issues normally the province of a medical association led to one attempted union breakaway based around the problem of reorganisation of work in one hospital in line with medical insurance. The Petersburg union saw the problem as outside the union's jurisdiction of protest: "We may be consulted or we can advise, but [reorganisation by managers] isn't within our sphere of authority". This seems to make a division of competence *between* the union and the authorities regarding health service matters, and merely serves to strengthen the hand of the state against the profession.

Conclusion

The attempts to achieve interest representation for the medical profession in Russia is problematic both because of the legacy of Soviet trade union practice *per se*, and because of the deliberate and accidental fragmentation of the medical profession since the foundation of the Soviet health care system. The difficulty in creating new unions suggests that the presence of a broad-based trade union for all medical personnel will persist. How successful unions will be in expressing and defending members' interests depends in part on their strategies. To develop into oppositionalist Anglo-Saxon models of behaviour runs the risk (survived in St. Petersburg) of being sidelined and undermined by deliberate executive action. To maintain old strategies of co-operation within a supposedly corporate framework risks perpetuating factual irrelevance. Either mode of behaviour within economic crisis threatens ineffectiveness, and possibly resentment. However, the strategy pursued by the St. Petersburg union appears more successful insofar as personnel changes were achieved at their behest, some political influence has been exercised by mobilisation. While under greater threat of sanction than in the union in Volgograd Oblast', it appears more robust.

The successful formation of a medical association in St. Petersburg to express the interests of higher medical personnel is dependent upon certain factors – a more pluralist and open health policy system, a more stable insurance system – as well as a sturdier basis of membership. It has been able to carve out a role expressing exactly those kinds of professional issues that the broader-based trade union has not been able to deal with. Indeed, one of many paradoxes in this situation, the strength and independence of the trade union in focussing on labour conditions and using strikes and other form of protest that many doctors object to, has helped to define better the space for the association.

The second paradox is that although the Association in St. Petersburg also reflects unease about insurance, it is the insurance system itself that has given the impetus for doctors to organise against other actors. Without the insurance companies, without the separate role of the head doctors and administrators as commissioners of health care, without the territorial fund, the understanding of doctors as one side of the provision of health care among many might not have developed so well. The "others" that throughout the last fifteen years have apparently plagued the lot of doctors, are drawn into the open.

The lack of strong representation *per se* as providers of health care is troublesome. The lack of continuity in Russian health care policy making about which many interviewees complained, with radical changes introduced without consultation and amendment is surely in part conditioned by the inability of the medical profession to articulate collective

responses independent of state structures. They do not effectively use their monopoly position to garner concessions, nor have they in general performed the task of educating their members in relevant policy options in order to mobilise. Furthermore, while a conservative veto effect from associations or unions as embedded institutions can act as a break on dramatic, "rationalist" policy reform, the division between association and union appears to remove that veto threat by placing broad health service reform outside the remit of both.

8. The Insurance Medical Organisations and Territorial Funds

The Insurance Medical Organisations and the Territorial Funds and are the two truly innovative parts of the new system of financing, and the former more so than the latter. As we saw in chapter five, the dominant classification of variations in health care financing across Russia are defined by the activities of these two organisations. In this chapter I seek to set out the operation of each, relationships between them, and to examine issues of systemic stability and development. In the subsequent chapter I investigate some of the theses put forward in this chapter using country-wide data.

Insurance medical organisations

> Insurance medical organisations are legal persons, being independent economic subjects, with any (in accordance with Russian Federation law) basis of ownership, possessing statutory funds necessary for the realisation of medical insurance and for organising its own activities... Health care departments and health care units cannot be the founders of insurance medical organisations...[They may own shares of an IMO] up to 10% of the total. (Article 14, 1991 Law on Medical Insurance in the RSFSR, following 1993 revisions)
>
> Insurance medical organisations have the right
> - freely to choose a health care unit to render medical help in accordance with an agreement; to take part in the accreditation of health care providers;...
> - to take part in defining tariffs for medical services, to bring court action against a health care unit or (and) against a medical worker for material damages of a physical or moral kind done to one of their insured persons.
>
> Insurance Medical Organisations are obliged
> - to realise compulsory medical insurance on a non-commercial basis;
> - to conclude agreements with health care units for the rendering of medical help to those insured under compulsory medical insurance;...
> - from the moment of concluding the agreement of medical insurance to give to the insurant [NB. usually employer] or the insured an insurance medical policy;
> - to return to the insurant or the insured part of the contributions, if this is provided for in the agreement; to control the scale, length and quality of medical help in accordance with the conditions of the agreement; to defend the interests of the insured.
>
> To provide stability in their insurance activities, insurance medical organisations should create reserve funds. Insurance medical organisations do not have the right to refuse to conclude a compulsory medical insurance agreement with an insurant who conforms to the current conditions of insurance. (Article 15)
>
> State licences for conducting medical insurance are granted by the offices of the Russian federal service of insurance activity oversight, in accordance with current legislation. (Article 16).

The insurance companies are the most institutionally innovative part of the entire system, and most symbolic of its pluralist aspirations. Their chief novelties are in their complete (in

principle) legal independence from the state and from the state health care system (there is no tradition of non-state health insurance in Russia) and their role in performing external medical care audit. Given that tariffs for medical services are set at the regional level, that both insurance contributions and the per capita funding received by each insurance company cannot vary within any one region, and that insurance companies must allow their insured to go to any institution in the region, the main dimension of competition and choice in health care is between insurance companies fighting for contracts. This competition is (in theory) based upon their ability to provide a better range of services (above the legal minimum of the territorial programme), to defend patients against poor practice, and for the various compensation schemes available in the light of poor practice. Their money is made through efficient monitoring of health care, including the encouragement of more cost-effective practices.

They have been met with a great deal of resistance on the part of medical professionals, parts of the population and among many politicians. They have also been troubled by a lack of definition in legislative and normative documents, by poor economic circumstances that make performing health insurance difficult, and by a weak natural constituency from which to garner support. The survival of IMOs in many regional systems is questionable. In this study there is a marked contrast between the institutional dynamics of St. Petersburg and Volgograd Oblast'.

Lacunae in the regulatory framework

The regulation of IMOs was initially so underdeveloped as to be effectively absent: their licensing, how they remunerate hospitals, and how they should perform their audit function. In 1992, the first medical insurance company in St. Petersburg, MedEkspress, tried to obtain a license from the ministry of finance, which at that point dealt with such matters.

> We were sent a long letter with many questions, asking our specialists to go to Moscow to answer these questions. And so our lawyer, the insurance director, and the actuary went to Moscow to the head of the licensing department in the ministry of finance. There was to be a long conversation about what they didn't like in our document. It finished in 15 minutes. Then all his colleagues in the licensing department were called together, and then our specialists read them a four hour lecture on what medical insurance actually is. It was really true! After that we got our licence without any questions. On the one hand it's funny, on the other it's a story about how these people came from St. Petersburg, which is thought of as the periphery, and taught the licensing department in Moscow about medical insurance.

That is, even though the law had been passed and licences were to be handed out, there was little understanding in Moscow of how the system should operate. This problem appeared to carry on at least into 1993: from Altai Krai it was also reported that no insurance

medical organisation could get licensing because the Ministry of Finance wasn't prepared for it (MG 22.1.93/7). The deputy head of the federal insurance oversight service K. Turbina admitted at the end of that year that there simply hadn't been enough time to get ready for the introduction of insurance medicine, that there were holes in the law that they had to stitch up as they went along, and in particular a lacuna of normative documents (MG 19.11.93/2). Eventually at the federal level the umbrella association of medical insurance companies found itself helping the finance and health ministries write the rules for the existence of its own members (MG 7.7.95/4).

Infrastructure for the collection of statistical data, essential for performing actuarial calculations and amongst other things, tariff setting, was also primitive. Again the experience of MedEkspress is informative, when trying to operate voluntary insurance in 1992 and 1993.

> It was necessary to conclude an agreement where we could buy statistics from the health care committee. They were done specially for us. Of course our belief in them was weak. When we worked out the tariffs, I'll tell you a secret, we had a coefficient of three, we multiplied everything by three just in case. And that's how we got our tariffs.

Such data gathering is now performed and co-ordinated by the territorial funds in their capacity as underwriters and stabilisers of the system; dissemination of such data to IMOs appears more open in St. Petersburg than in Volgograd Oblast' – one of many examples where the relationship between fund and IMOs is more symbiotic in the former than the latter.

Specific methods of payment were not considered in federal legislation; they were part of the free right of contract given to the IMOs. In health care, as we saw in chapter 4, payment methods are one of the most important aspects of controlling finances and improving services. According to the head of the research centre at the Ministry of Labour's institute of employment within the Russian compulsory system there are seven different permissible ways of paying for primary care (including by service, by consultation, by per capita funding, by diagnostic group and so forth) and four different ways for hospital care (Degtyarev 1997). This gives potential for significant variation across territories and also within them. It can involve not only methods for reducing excessive expenditure by giving incentives to health care providers to choose more efficient methods of treatment, but methods such as fee for service, that with a third-party payer can lead to increases in medical costs and have little influence on hospital referral rates. The independence of IMOs in this kind of activity (which is supported by the head of the Federal Fund (Grishin 1996)), makes them easy scapegoats in financially difficult conditions.

This lack of definition in their status and activities may perversely have punished those who started out early with insurance medicine, forging ahead with creative reform. For example, in Volgograd, insurance companies, operating initially with the right to vary the level of contributions, had to devise new methods of calculating their tariffs (on a lower contribution rate) without much guidance on the part of central or regional authorities (albeit under the general guidance of an Oblast'-wide steering group). From the Oblast trade union chair:

> We suddenly had a lot of them. In some Oblasts there were two, three, where they developed the system later, but we went quickly and made mistakes and there were lots of them. So many IMOs would be possible in developed countries, where there is already as developed insurance system, where there's experience. But we didn't have such lessons.

Better initial regulation of the insurance market would clearly have helped to avoid the chaos that led to the reform of the system in Volgograd. However, the model of organic IMO growth implicit in the 1991 law, decentralisation of much responsibility, and indifference from the central Health Ministry militated against this.

The Problem with *Ekspertiza*

> These insurance companies need to do their analysis, it's they're weakest point. They need to raise quality and lower cost. But today they can't do this 100%. Some are better than others; some don't do it at all, for example, in this *raion*.
>
> Vasiliostrovskii *raion*, St. Petersburg

"Ekspertiza", or expert analysis was an innovation in Russian health care. Having had very little oversight of any kind before 1991, very little was done in the way of preparation for the practice of medical audit. As with payment methods, insurance companies initially had to entirely develop themselves techniques for monitoring the services for which they were paying. Generally speaking, this was not done successfully, and almost all respondents expressed some degree of unhappiness with how the process was carried out. Most commonly the complaint was that the IMOs operated without enough medical expertise, seeking merely to enforce established norms of practice for the *average* patient, fining where there was disagreement between standards and concrete presented accounts, with little regard to circumstance. The paradox of developing these methods was drawn out by the head of the Voronezh Oblast' IMO association – that there needed to be a unified methodology so that hospitals could understand what was required – yet *ekspertiza* was supposed to evolve organically (MG 31.7.96).

From the research sites:

> Alas, the analyses are merely formal – "you didn't do this analysis, you didn't hold the patient for two days *etc.*" – and they fine our hospitals, and these fines come from left right and centre.
>
> (Petrodvorets, St. Petersburg)

> The IMOs operate only through paper, they take money away from the payment, when the question doesn't depend upon the doctor's behaviour. One needs to go into each case in detail.
>
> (Sovetskii *raion*, Volgograd)

> They work too much with paper, counting the bed-days
>
> (Krasnooktyabrskii *raion*, Volgograd)

Even the head of the Petersburg IMO association declared that it "wasn't at the level we had hoped it would be, although we've made progress". According to the minister of health Tsaregorodtsev (1996) "the defence of the rights of patients is obviously inadequate". Part of this problem is the sheer scale of the task – insurance medical organisations have taken to using these methods of analysis in order to discover possible cases of malpractice. But also part of it is the lack of experience and skill in undertaking medical audit. Many universities in the regions now offer courses in medical *ekspertiza*, and in some these are organised by the fund.

It is important to remember that the issue of *ekspertiza* was central to competition between IMOs. There is a paradox in seeking regional-wide solutions to the skills deficit. As the head of Sovetskii *raion* health care argued "There is no competition. What kind of competition? They all go to the same school of analysis". Although there are also issues of efficiency and competence, it is crucial to recognise the role poor handling of medical audit has played in making insurance companies unpopular.

Lack of Finance

Many of the problems of inadequate finance have been dealt with earlier in this thesis. In particular here I wish to examine how poor finances can undermine the work of IMOs in improving the operation of the health service. The head of MedEkspress in St. Petersburg recounted how in the early 1990s they were able to invest in incentive mechanisms, but latterly such innovations have become difficult:

> And so we created a fund in order to reward polyclinics that didn't hospitalise as much. When there were no problems with money this all worked. And the hospitalisation rate really was falling. The polyclinics were interested in this. And we had our experts constantly checking whether someone was really due to be hospitalised. There was a whole load of measures to ensure that they always referred when they had to. Now there is a fund of hospitalisation, but there is no hard cash. We cannot stimulate the doctors and polyclinics, and so the fall in hospitalisation stopped...Today is very bad, you can see around you the problems with the economy. IMOs just send on whatever money they receive, there are no reserves, and so none of those measures can be implemented

Many IMOs had also sponsored medical procurement to ensure the availability of drugs, while in Volgograd one IMO had been experimenting with compensation schemes for victims of malpractice. These and other such projects become virtually impossible with severe under-funding. Quite simply, the spare money isn't there for them to form special reserves.

As mentioned in Chapter 6, when the IMOs cannot fully finance health care providers, exercising authority through medical audit becomes difficult. If the money is not there to pay for the treatment, criticising a doctor for being unable to render the full treatment becomes a nonsense. As a representative of the St. Petersburg territorial fund put it,

> Doctors say, "if you want to control me, you can start by giving me enough money, and then you can audit me. If it's only a half, what are you going to check?

Bereft of funds with which to invest and experiment, and finding themselves imposing fines on under-funded services has thus prevented the IMOs from pursuing what Walshe (2002) has called "compliance" strategies: working with health care institutions in trying actively to improve practice and services for patients, leaving only "deterrence" strategies: adversarial, relying on penalties (fines *etc.*) to elicit good behaviour. As Walshe points out, the latter can lead to resentment, and attempts by the regulated to subvert both regulation and the regulator. The St. Petersburg territorial insurance principle does mitigate this development somewhat by allowing exclusive working relationships to develop between insurance companies and a set of health care institutions.

The sidelining of the IMOs Volgograd Oblast', whereby they are paid to monitor, but gain no financial benefit from doing so (thus, goes the thinking, saving money) has of course undermined their role even further. As the vice-president of the Volgograd Oblast' IMO association put it, "The whole aim of the system has disappeared. Tell me, what's the point of operating in it when for insurance companies it's all the same whether or not any procedure has been done correctly or not?"

Institutional and cultural resistance

The ill-preparedness of the appropriate ministries towards the operations of insurance companies has been noted above. It should also be noted that there is active resistance to the activities of insurance companies on the part of local-level institutions. There is, as reported above, resentment at the imposition of medical audit when it is performed. As the head of the Petersburg association put it:

- Have you done anything to limit this opposition amongst medical workers?

How would you do it? People resent the police, the tax service, why not us as well?

The problem is complicated when payment methods involve a good deal of administration on the part of the health care provider, and when, as we saw above, the methods of carrying out analysis are clumsy. Furthermore, there is a perceived cultural resistance towards broader notions of those patients' rights (and backed up by what research there has been into the ethics of Russian and other Soviet-trained doctors), which are supposed to be defended by the insurance companies.

There may also be a certain degree of professional exclusivity. According to the head of MedEkspress, the majority of people who came into medical insurance are not actually medically trained. Despite the medical qualifications of the analytical experts themselves, some *raion* heads of health care expressed mistrust in the abilities of the analysts to do their jobs. As one Petersburg head put it "They're not doctors, these insurance companies, they're financial institutions. How can they understand the work that we do?" The tradition of super-specialisation in Russian and Soviet medicine no doubt reinforces this feeling of exclusivity.

The resistance to the activities of the insurance companies appears also to be embodied in the passivity of a population unfamiliar with insurance, at least according to the head of the Petersburg association of insurance companies:

> The mentality of people is weakly developed. People just don't understand that we, the insurance companies, are their defenders. They don't understand that we help them save money in the budget... People, when they are unhappy with the service they get don't complain, even when we suggest this to them. They're frightened of the doctors, of the consequences.

Similar sentiments, examined below, are expressed by the deputy director of the Volgograd Territorial Fund. However the vice-president of the Volgograd medical insurance company association appears to put any popular indifference down to the weak position of the insurance companies and the distortion of the law by the territorial fund. However, estimating the truth of this particular point is difficult given the variable record of insurance companies in following up complaints or even recording them.

Finally, and perhaps fatally for many insurance companies, their independence from state structures left them open to scape-goating from those state structures and the state media they controlled for any problems that appeared. Both in St. Petersburg ("they accuse us of all sins...it's convenient for them") and Volgograd the insurance company associations expressed themselves to be victims of such practices. In particular, there is evidence to

suggest that the territorial fund in Volgograd Oblast' sees the insurance companies as competing with their own interests. The ability of territorial funds to mobilise resources against the insurance companies is examined in detail below.

Systemic problems and the advantage of the Petersburg territorial system

As mentioned above, the productive-territorial principle of insurance (as opposed to the purely territorial) may undermine the ability of insurance companies to develop productive working relationships with health care providers. However the Petersburg territorial principle also helps to keep insurance "cleaner". Insurance companies are intended to provide, in the words of Burkin "legally and economically independent structures which are subject only to the law and stand up for the interests of patients". However, insurance companies are not as independent as one might hope. Burkin himself noted early on the tendency for the municipalities to "recommend" to local employers which insurance company they should contract with [MG 3.9.93:7], based on personal connections between heads of the two organisations. The Deputy director of the Volgograd Fund talked about this in detail:

> The insurant [the employer] will search using some kind of mechanism. Many insurance companies will try to make sure they are chosen. What criteria are there? As a rule it is absolutely a telephone rule. Let's say I am the director of an insurance medical organisation. I've lived here a while, and I try to find a head of an enterprise through my acquaintances. And I try, in organising this insurance medical organisation, I try to get the biggest insurant-enterprises. If I manage this, I'm not worried about anything, I know they are only going to insure with me. And so to try to do ratings for these insurance companies – we tried. In 1997 we oversaw a process of competitive ratings for insurance medical organisations in Volgograd. The process didn't do much.
>
> - *What was the basis for the rating?*
>
> There was a commission. There was a preference for certain companies. But these preferences were based on concrete criteria... Capital, the number of insured, computerisation, the level of expertise, there were a mass of them. The members of the commission were specialists, organisers etc. They published a bulletin - how to judge an insurance medical organisation. You could get 200 points. Only 4 got over 100. This was widely publicised, widely. But this didn't influence the insurance market

.

But this is not simply a case of endemic corruption, although it certainly is corrupt. Given the principle that employers can select their own insurance companies (the 'productive' principle of insurance) in a period of many start-ups requiring capital reserves, it is not surprising that many companies chose to form their own insurance company. Some may even do this under the false impression that they can make money out of it, according to the head of the St. Petersburg association. Not only does this lead to non-competition for contracts and possible stagnation, but a lack of adaptability in changing economic

circumstances. As the head of MedEkspress in Petersburg noted, many of these large companies folded or became insolvent, unable to continue supporting the insurance companies.

Indeed, it is the territorial principle (where people are insured by municipality) that the head of the Petersburg IMO association argues has saved the insurance market there and has stabilised funding. Firstly, any relationship between the ability of employers to pay their contributions and the receipt of funds by the insurance company is broken. This removes both the temptation to court the sorts of large enterprises that provide immediate funding but commonly have weak long-term economic prospects, and cash-flow problems. Secondly, it reduces the complexity of the system dramatically. Instead of there being over 100,000 employers in St. Petersburg, for example, all of whom need to conclude an agreement with a medical insurance company, there are just 19 municipalities. And of course, in the current fluctuating economic conditions and housing market, changing jobs is more likely than changing residence. According to the head of MedEkspress, (and newspaper reports) the introduction of the productive principle in the surrounding Leningrad Oblast' has led to the collapse of the system under "a mountain of papers".

Indeed, it has been this kind of complexity that has undermined the work of the insurance companies in other areas. For example, in the initial model in Moscow Oblast', despite the relative health of the insurance companies in a cash-rich environment, they were identified as the weak link in the flow of information (Lyabin, Solodkii and Shilyaev, 1996), while as mentioned previously, in Moscow City the problem of getting one's policy stamped every time one changed work led to the urgent development of plastic chip-card replacements. There are also problems where the system of agreements between insurance companies and health care providers conflicts with the free choice of institution: one insurance company acts as the guarantor of care for an institution, and has to extract money from a patient's insurer if no agreement exists between that insurer and the provider in question.

Corruption

As noted above, the start-up process awarding of contracts generated incentives and opportunities for corruption. The problem is compounded in an economy where political and personal economic interests are so closely entwined through a remaining deep integration between executive power and production and exchange. Although in St. Petersburg the period of corruption initially associated with working by the productive principle appears to have been temporary, in Volgograd it continues to draw a shadow over the system. The

"bazaar" system (according to the Volgograd territorial fund) that grew up around the original system they initiated, according to the Meditsinskaya Gazeta correspondent, created a "rather complex aura" around the insurance companies (which Burkin replied had been "created by the media").

Of the sixteen insurance companies operating in Volgograd Oblast' in 1997, three were found to have either embezzled funds, wrongly invested them in equities, or simply run out of money. A fourth – indeed, Burkin's – had been found out to have problematic accounting procedures (Niklyaev, Samarina and Yakovleva 1998) – although according to Burkin there were ulterior motives on the part of the Territorial Fund in pushing this case. It should be pointed out that in a slowly developing legal situation with some laws dating back to the anti-commercial past, and some simply contradictory or unworkable, the possibility of prejudicial prosecution is high.

Accounting procedures and anomalies also opened the door to corruption. According to Burkin there was a "black market" in false accounts from hospitals

> OK, so this 3.6% is too low, it should be about 8%. But where this money goes, is already not entirely clear. Until June this year, we tried to support patients, and I was one of the initiators of a system where we gave the patient back the cost of the drugs they had brought to treatment. What happened? We cannot check every case. The patient bought the medicines, brought them along, handed them over. The hospital doesn't pay them the money, they are treated at their own expense. But we don't know this. And so the hospital presents me with a bill *including* the cost of the medicines.

Various attempts at investment and incentivisation run a problem of standardisation – the standards will inevitably be approximate descriptions of desired behaviour (for example, using hospital records as true records), providing an opportunity for corrupt practice and siphoning away of funds. In a system with low funds and a certain moral anomie, corruption becomes a danger. In one Oblast', an almost perfect equivalent of the scam run by Chichikov in Gogol's *Dead Souls* was found. Insurance medical organisations were presenting to the territorial fund lists of the insured who had moved from one employer to another, and so were not actually still on their books. The per capita funding arrangements meant that the insurance companies would receive more for the number of souls[1] on their books. As a result, over 100% of the population was covered by insurance.

[1] It should be pointed out that the word 'soul', *dusha*, is also used to denote a person, especially when counting heads. In the novel, Chichikov buys the title deeds of dead serfs to give the impression of great wealth, to allow him to obtain a title for himself.

Political weakness

No one except the insurers themselves considered themselves influential in the development of overall health policy. Indeed, the head of the St. Petersburg association also played down their influence:

> There is a picture that comes from the Ministry of Healthcare, from the Duma commission on Healthcare, all these medics, they want to keep the beds, they are self-interested. We have been making suggestions for four years, but they refuse to do what we have suggested. Why? Sometimes someone doesn't act because they can't, and sometimes because they don't want to
>
> We are quite a weak organisation now. At the moment patients don't believe in us. Doctors listen to other medics and they blame us for everything.

In Volgograd, the very vocal and active Pavel Burkin, at least, appears to have alienated most other policy actors, and certainly many of the ones I had talked to. Institutionally the insurance companies have only one seat on the boards of the territorial funds, compared to strong representation by the administration, and also the medical profession, medical association and local legislators. As attested to above, they appear to have very little moral or financial authority to exercise over other actors. Their expenditures are tightly controlled even when there are enough funds; lobbying and campaigning *per se* is difficult, especially when such actions would lead to a closer analysis of their practices by those institutions they would be likely to be criticising.

Who can the IMOs rely on for support? As reported in previous chapters, there is evidence in St. Petersburg that enterprises that wish to have more control over the health services they can provide for their workforces support IMOs as a means to achieve this. As discussed directly below, municipal health care heads in Volgograd also wanted more influence over health financing policy than operating solely with the fund would allow. More importantly, some territorial funds, including that in St. Petersburg have moved to "shape their bureaus" (Dunleavy 1991) in other than simple budget maximising; seeing the IMO system as freeing them from day-to-day management of payment and medical audit. The organisation responsible for Fund oversight, the federal fund, has also moved to support IMO operation wherever possible.

These sources of support are not necessarily cohesive; moreover they depend upon a belief by protagonists that operating along these pluralist lines will achieve interest maximisation. As evidence by previous chapters' discussions of post-Soviet attitudes to administration and management, such an outlook cannot be taken for granted.

The potential role of IMOs – independence and innovation

In the face of these problems, it is worthwhile being reminded of why IMOs are supposed to exist. Their independence from governing institutions is critical. If the insurance companies are to be the defenders of the rights of patients, they cannot also be implicated in power structures whose stronger interest is the maintenance of, and defence of their own health care institutions. This is the view not only of the St. Petersburg territorial fund representative (see quotation below), but also of the head of the Federal Fund Vladimir Grishin, whose defence of IMOs as the proper defender of patient rights (MG 27.10.95/4) is one key factor in their survival. Moreover, their independence also helps support the fairness of the medical audit system: it is common sense to suppose that complaints against these independent bodies will be heard more fairly by the institutions of power than would complaints against quality control imposed by the administration. As the head of the St. Petersburg IMO association pointed out, "When they [the administrations and health care providers] unite, it becomes a matter of defending the rights of medics and not of patients."

Their locality and focus on matters of audit and cost control also allow them to develop a better relationship with their insurants, particularly, the municipalities. They are, in theory, able to tailor the insurance programme to the needs of the insurant, to adapt to local conditions in a way that more monolithic state and parastatal organisations would tend to find costly in terms of co-ordination. As the head of health care in Dzerzhinksii *raion* in Volgograd put it,

> When we contracted just with the insurance medical organisation, we could negotiate with them about various conditions. But with the fund such negotiations just don't happen, because it's an organisation that isn't very accessible for all insurants. It was easier to work with insurance companies than it is now with the fund filials.

Indeed, in Volgograd where originally IMOs dominated, four of the five administrators expressed a nostalgia for the previous system citing precisely the good working relationship. In St. Petersburg, although in general more critical of the IMOs, similar comments were made by two respondents. However, as indicated above, such good working relationships between health care providers and IMOs are dependent upon adequate funding.

Given that the basic framework of health insurance in Russia is not well-focussed on the solution to health care problems, IMO locality and competitive motivation to cut costs and improve care could provide the spur to rationalisation of resources and investment in more modern treatment. Examples have already been given of reducing hospitalisation rates and securing pharmaceutical provision. More importantly, many experiments in St. Petersburg, such as introducing general practice and payment by diagnostic group, because of its territorial insurance principle that simplifies the insurance field, have been undertaken

by the municipality and the IMO co-operating. The separation of purchaser and provider here allows for clearer task management; specialisms acquired by IMOs can be transferred from one *raion* to the next.

Of course it should not be forgotten that the situation for IMOs in St. Petersburg and Volgograd Oblast' are very different. In St. Petersburg they are treated as an integral part of the financing mechanism, whereas in Volgograd they are being pushed out of the system. As stated above, this seems to reflect different bureau-shaping strategies between the two territorial funds. Indeed, the well-being of the insurance companies depends in no small measure on the activities and policies of these funds, to which we now turn.

The Territorial Funds

> Some think that insurance medicine is not needed, things were fine before. Others say that it is necessary, but in a freer version, without the territorial fund... In my opinion the system that we have now has a good basis – it is expedient [*tselesoobrazno*]. The Territorial fund provides a general stability to the system. We would cope with [an absence of medical insurance organisations], but on the other hand, the medical insurance companies make sense for the CMI system, so that there is an independent control of quality. The Territorial fund wouldn't be able to do that kind of control – we are subordinate to the organs of power all the same."
>
> Territorial Fund representative (strategic planning), St. Petersburg.

> We have come to the conclusion that the current system of insurers isn't good. It's a superfluous link.
>
> A deputy director of the Territorial Fund, Volgograd Oblast'.

> Territorial Funds had in reality significantly broadened their powers in ways not foreseen by the Law, in particular in their activities as insurers. In a host of territories, the funds are trying to take on the duties of healthcare administrators, without bearing any of the responsibilities. From the state system the funds are attracting significant resources to support their own infrastructure.
>
> Summary of a report by Galina Dzilieva, the vice-head of the department of medical insurance, Ministry of Health and the Medical Industry (MG 28.4.95)

Key to understanding the differences between the territorial funds in the two research sites are the contradictory pressures under which funds in many regions have to operate, and their attitude towards their own role in the funding and development of healthcare.

In the amendments to the law on insurance in 1993, territorial funds were empowered to gather contributions, underwrite the stability of the system (for example, stepping where IMO had gone bankrupt) and to take on insurance activities as a means of guaranteeing the availability of insurers across any particular region. It thus could enter into the fringes (and deeper if necessary) of the market for the management of insurance money.

It thus had two functions that often ran contrary to each other: on the one hand to be a quasi-autonomous governmental organisation regulating a largely independent insurance system that would provide market efficiencies and innovations where possible; and on the other, (because of local peculiarities of geography or economics) to provide insurance where the IMOs would not. Thus the conflict lies in whether the territorial fund works with the IMOs as part of an integrated system, or whether the fund begins to duplicate IMO functions, and as a result begins to challenge them for control of resources. In St. Petersburg there has evolved a distinctly co-operative system, in Volgograd Oblast' a conflictual one. This next section examines the nature of the Fund behaviour and experience in the two sites, before examining the main points of conflict between fund and IMOs.

As seen in chapter 5, the Volgograd Oblast' Territorial Fund – in contrast to St. Petersburg – has chosen to expand its activities dramatically, in effect to empire-build. Having played a major part in the reassertion of order in the system following the chaotic years of 1994 to 1997, it expanded its influence further over the system by deciding, from early 1999 and in contravention of the federal law, to fund healthcare institutions directly, rather than let the money go through the insurance companies. While still responsible for auditing treatment, IMOs only received a retainer, with no revenue from financial penalties. Most of the work previously carried out by the insurance companies was now performed by the six (soon to be three) filials of the fund. In short, the fund had come to dominate the healthcare system. It now funded many projects outside the insurance system, (such as emergency care and long-term care for war veterans) and in the face of poor non-worker contribution rates from the budgets of the municipalities appeared to see itself as the only institution properly capable of performing necessary tasks in health care. It administers resources apparently quite brusquely – sometimes in a rather authoritarian and possibly vindictive manner, which might be to the detriment of the integrity of the system in the short run. For example,

> "Employers paid up, but the municipalities should have paid, but didn't. We have to subsidise from other territories, which leads to a general lowering of funding. We have no levers to force these municipalities to pay up. Therefore, in this filial [he indicates], the administration didn't pay, and we don't send money to them for this. And in the Northern filial there are two *raiony* that have large enterprises, and they gather much money into the budget. And the budget is able to and will pay up. In these regions there is more money"
>
> Deputy director, Volgograd Territorial Fund

Indeed, the general approach of the fund is summed up both in the irony of the question and in the answer in this exchange between a Meditsinskaya Gazeta correspondent and the Executive director of the fund Aleksandr Niklyaev early in 1998

Corr.: Could one call your style of governance "democratic"?
Niklyaev: I'll answer that with the words of one of the most influential American managerial experts: "Any effective form of governance at the closest examination seems to be dictatorship". (MG 27.3.98/5)

The St. Petersburg territorial fund, on the other hand, sees itself as only one part of an overall balanced system of insurance. While in St. Petersburg only the head of the medical filial of the Petrovskii bank (the banker for nearly all medical institutions in the city) and the chair of health care in Kirov *raion* were prepared to consider that the fund had occasionally interfered beyond its remit in addressing certain questions of medical practice (and then not considering this particularly worrying in its extent, although incorrect) in Volgograd the fund was considered to be acting almost wilfully, and without much possible redress. As the head of the Volgograd city healthcare committee remarked:

"The authority [of the fund] has certainly increased. But they aren't working well, but they're not working with market principles. Let's say there's a patient who's being treated. The hospital should be paid for the treatment, but the fund just funds the pay (1st article) of the medical workers concerned."

This remark also points out one strong distinction between the two funds: their perception of the role of the fund in the dynamic development of healthcare in their regions. In St. Petersburg the fund clearly sees itself while not necessarily a direct innovator in healthcare (as that would step outside its remit) at least as assisting such processes, as the head of strategic planning suggests:

We check all the documentation and licensing. We gather all the information. We don't involve ourselves in medical decisions. We may raise questions in examining documentation, but we don't directly intervene...With Compulsory Medical Insurance there is potential for reform – a potential that we haven't used yet.

- How could this be done?

Through economic reform. The Territorial Fund is an economic organisation. We've got a good deal of economic information, we can judge the economic efficiency of the healthcare system, and suggest directions – to improve the economic dynamics.

In contrast, the Volgograd Oblast' fund dismissed such ideas. Instead he appeared to see the fund as merely the distributor of health resources; efficiency improvements were up to the health care providers alone.

Under this system where is the possibility for innovation? We pay for the illness. It isn't our responsibility to help people innovate. There are things that we do, and things for the budget. We are meant to deal with pay, medicaments, food, laundry. That's all. All. The [municipal]

healthcare administrations - they must pay for administrative costs, rent, energy, equipment, drainage, repairs.

In another part of the interview, the deputy director suggests that 5% of the Oblast' budget should be put aside for "innovation" – that is, it is purely the task of the administration. Thus, although it dominates the funding of the system (in 1998 it claimed to fund the lion's share of all healthcare costs), and is seen as both authoritative and authoritarian in its dealings with other parts of the system, the deputy director described the fund as "an executor. We simply do."

Indeed, one might see it as a paradox that the fund that dominates more perceives its true functions more narrowly. But the paradox is resolved by considering that the expansion on the part of the Volgograd system was predicated on the poor operation of an ambitious and pluralised system. The expansion of its authority was tied with abandoning these more sophisticated financing mechanisms. In St. Petersburg the fund had a more complex role because it operated in a complex system.

Balance and the "vertikal'"

Earlier Chapters have described the disorienting effect of the removal of the Soviet command system. Here it is important to recall how governing structures in Volgograd Oblast' were especially problematic, with policy co-ordination between regional and local government highly unsatisfactory. This was also the opinion of the Territorial Fund. In particular, the Oblast' administration was seen as "weak"; there was delay and inaction in the Oblast' Duma in translating them into local law; those responsible for trying to extract as much budget funding out of the Oblast' budget were seen as ineffective. The head of the Oblast' health care committee had been advised by the Territorial Fund to "kick up a fuss, and demand" money that was going into other areas – but with little success. In short, health care policy was chaotic, under-regulated and under-funded.

As a result, the Territorial Fund's extension into more general organisation of healthcare financing, bypassing the insurance companies and dealing directly with healthcare institutions was predicated on saving the system. Despite deep reservations at such unconstitutional and unregulated expansion, one municipal healthcare chairman in Volgograd saw it as "a necessary restoration of the *vertikal'*...I don't like it, but given our financial crisis, what else is there for us to do?" Bluntly put, although the territorial fund representative in Volgograd interviewed was no different to others in lamenting the loss of the *vertikal'*, his organisation was in a position to do something about it, by asserting its

undivided authority in health care financing. No other institution had the ability or the political will to prevent it.

In marked contrast to this situation, most respondents in St. Petersburg were quick and unequivocal in ascribing clear authority to the city healthcare committee. Furthermore, they considered it not to operate wilfully or arbitrarily, but open to democratic considerations. Indeed, the willingness to debate and the desire to reach consensus appeared to frustrate the fund.

> - *Does St. Petersburg have an advantage in that it is a "reformist" city?*
>
> This is a political image [*obraz*]. Sometimes it's true, sometimes it's not. In many other cities reforms proceed quickly and normally. But in St. Petersburg the city is rather politicised, that is, many changes which are wise and intelligent don't happen because there are political forces and inter-relations that prevent completely normal changes that no one is against. St. Petersburg is a very democratic city, but this implies a long process of negotiations... and because of this many decisions aren't taken. In many other cities where political relations are not so developed, decisions are taken more quickly.
>
> - *What kinds of decisions?*
>
> Well, Compulsory Medical Insurance was implemented with great difficulty, connected with the need for agreement from different sides.

That is, even in the context of severe arguments between the legislature and the executive regarding healthcare financing and organisation, there was no power vacuum into which the fund could step – even in the name of reforms "proceeding quickly and normally". Unlike Volgograd Oblast', planning functions were held by the same organisation that controlled the budget allocation and ultimately controlled all the health care providers.

Furthermore, with St. Petersburg operating on the territorial principle of insurance as opposed to the territorial-productive principle, the municipalities had both greater leverage over how insurance companies (and indirectly the fund) dealt with financing their institutions, and an easier task in monitoring the relationships between insurance companies and their health care units. As the head of health care in Admiralteiskii *raion* commented:

> At the moment we have two contracts with two companies for the whole *raion*. There are 6,000 employers in this *raion*. That would be 6,000 contracts. It would be rather more complicated, maybe too much.

Compared to Volgograd Oblast', the relationship between the insurance companies, municipalities, the regional authority, health care institutions and the fund are simplified and in balance. The Fund's independence protects it from everyday interference; its control over insurance money enables it to exercise authority over the insurance companies; the insurance

companies have simplified contracting processes with large contractors, and may develop secure relationships with them. Unlike Volgograd Oblast', municipalities are not burdened with unnecessary expectations by the regional authority, as the city-subject is also responsible for financing them. And at the last resort, the city authorities may act to rein in the Fund, as occurred once in the 1990s when the Fund's governing body was changed – which, given the more democratic structure within the city health care committee, would occur with the support of the municipalities. The system is geared to co-ordination and conflict resolution.

In Volgograd Oblast' the matter is different. Firstly, as the head of the Volzhskii municipal insurance company commented, there are structural-political reasons that prevent co-ordination:

> These heads of administrations in the municipalities are not going to agree to closing down their hospitals and clinics by order of the Oblast'. These institutions give them prestige. They want to get re-elected...No one is interested in sharing their resources. Everyone is short of money...The Oblast' won't help the city there [Volgograd] or Volzhskii, because we are richer and they don't see why we can't look after our own people.

The deputy director of the fund also talked of "psychological" reasons for this break-up of power:

> I don't know if you have noticed the centrifugal intentions of various governing people [*upravlentsy*] – every Oblast' wants to be a country. Every *raion* wants to be an Oblast'
>
> - *What is this produced by?*
>
> Firstly, Russian mentality. There was always a strict *vertikal'*. Soviet power up to an even greater level. The idea of self-government is purely psychological...in fact everyone wants to be a *tsar'* of maximal power. And therefore local government is understood as a tsarism in the locality.
>
> - *Especially in the area of co-ordination?*
>
> Especially then. Soviet authorities had a rigorous *vertikal'*. Although we've moved to market economics, this outlook (*namereniya*) has remained. It's my opinion.

The Oblast' has, since the introduction of its own system prior to the general federal system, operated on the territorial-productive principle. Therefore the administrations – which were also in competition with each other for funds, were responsible for less than half the money going into the insurance system. The insurance companies themselves were drawing up contracts with tens of thousands of employers, who in the absence of clear information and systems of sharing information could not adequately judge which companies were better

than others (and so often relied on 'personal contacts'). The territorial fund, supposedly responsible for the day-to-day regulation of the system was operating in a system without norms or rules of transparency because the authorities, having originally legislated for one model, were supposedly caught out by the shape of the revised model which envisaged a much larger role for the territorial fund (according to the fund's Deputy Director). Health care institutions faced a complicated battle for resources from a wide variety of insurance companies.

The deputy director of the fund, justifying the fund's moves in sidelining the IMOs, described the situation thus:

> "I'd like to say that the system that was suggested to us, was basically one idea – to have a market economy. And we have to move away from this.
>
> - *Why?*
>
> Because over 5 years...the market economy tried to find its place. Unfortunately it has turned out like a bazaar. This has allowed the unbalancing of the system.

Thus the relative complexity of the system, allied to an inability on the part of elected and executive authorities to exert co-ordinated control over it led to the territorial fund exerting control. Valerii Sabanov, Professor of healthcare organisation and insurance medicine at the Volgograd Medical Academy, described the two problems in this way:

> "The Oblast' [administration] is weak, it does not have the authority to organise healthcare. It has to deal with the city, and with the other municipalities. Meanwhile the insurance system has the funds and therefore the levers to exercise control...

When it was put to him, that some concept of balance was "key" to the differences between St. Petersburg (a model known throughout Russia) and Volgograd Oblast' – that in St. Petersburg the city authorities were an adequate counterweight to the fund because of the ease of administrative control, he vigorously agreed.

The latent dominance of the territorial funds

In many interviews, and in many opinions expressed throughout the regions of Russia over the years since the inception of the system, there appears to be both a general tension within the relationship between funds and insurance companies, and some questioning from outwith of the need for both organisations to exist. The consideration by the Volgograd Fund of the companies as "superfluous" is applied in other interviews to both institutions, and reflects

general worries regarding the complexity of the system. Most commonly the complaint is that each takes resources out of the system. In the words of one Volgograd *raion* healthcare chair:

> Of course it's proper that the insurance companies, or the fund, take their 8 per cent, if they earn it. But to have both of them takes 16% out of the healthcare system. We don't need that, there isn't enough money... We should abolish one of them.

(It should be pointed out that these figures of 8% are disputed by both the IMOs and the Fund). A similar complaint is made by the chair of healthcare in Moscow Oblast' (which surrounds Moscow city):

> The territorial funds and the insurance companies are given the right to form from all the money that passes through them reserve funds, when this money is urgently needed by hospitals." MG 27.10.95/5

Sabanov argues

> ...But the thing is we have both the fund and the insurance companies. It's too complex. One of them – either one – has to go. I don't think it really matters which.

The abolition of one or the other would have a dramatic effect on the nature of the insurance system. To abolish the IMOs would lead, as the Volgograd Fund representative suggested, to competition between health care providers for fund money. To abolish the fund would leave open problems of oversight and balancing of funds, but would allow fuller competition between IMOs for contracts. Even the deputy director of the Volgograd fund describes the pre 1994 – fundless – system in Volgograd with some nostalgia:

> The first version of the law didn't imagine the territorial fund. We had an experiment here, our own. The Oblast health care committee was the initiator. There was a working group, including yours truly. We came up with a set of plan documents, which were then accepted by the Oblast' administration. We had a lot of insurance companies forming. At this point the supreme Soviet hadn't yet determined the norms as to how to proceed. We included differential rates according to the enterprise, the branch of the economy. This differentiation gave the enterprise bosses an incentive to lower problems at work. These differentials were based upon statistical analysis, and weren't in dispute. It was fair. The enterprise bosses were interested therefore in lowering morbidity among their workers, improving working conditions. All this was done before 1993... Here there was a financing mechanism, maybe with a few negative (*porochnye*) aspects to it. It had some defects...But then so did the [eventual] federal model.

Indeed, Pavel Burkin, the head of the Association of Insurance Companies in Volgograd, was active in campaigning against the Territorial Fund (indeed the 1993 model in general) as

an interfering burden upon the activities and freedoms of the insurance companies. (It is a testament to the friction between the two sides that in arranging an interview with him it became apparent he needed to meet somewhere where we wouldn't be overheard by any means – although he had been vocal on the pages of *Meditsinskaya Gazeta* in previous years.) He also considers the competition between insurance companies as healthy both in terms of their relations with the hospitals (they have an incentive to audit better) but for democratic reasons: that the territorial fund not only cannot be rejected as an insurer or monitor, but a lack of administrative co-ordination removes the possibility of monitoring the fund (Grishin, 1997)

However, a consideration of the structural situation of the insurance companies, as well as the experience both in Volgograd and of some other regions of Russia suggests that where there are tensions between the two types of organisations, produced by imbalances in the system, or by shortages of money, or pure political ambition, the territorial funds possess great advantages not so much in structural terms, but in the context of Russian politics and economics.

The effect of corruption

Corruption has served to make the insurance companies appear parasitic. The original law allowed those taking part in medical insurance to form their organisational capital "from *any* form of property". It also wasn't clear to what extent their activities were covered by Russian laws and regulations on insurance, which, as noted above, were incomplete. As even Burkin himself remarked on the behaviour of some IMOs in these conditions: "what did you expect?" As Niklyaev put it (MG 27.3.98, cited above),

> The previous way didn't suit us: the money went from the fund to the insurance companies, where the threads of it were lost. Clear information about where it went to just didn't exist. And then facts came to light so that it all became a matter for the law-enforcement agencies.

If too many insurance companies are or appear to be financially corrupt, then it is politically easier to consider them superfluous.

Moreover, as recounted above, there was also corruption in the way that contracts were awarded by employers. Burkin also claims that competition was squeezed out by, among others, business associates of the then vice-governor and one of the initiators of the original system, Yegin (a man, incidentally, considered by journalists in private to be something of a "gangster").

Of course, the fund itself, before its re-organisation in 1997 had also been found guilty of corruption. At one point it had 44 filials, three of which had started to act independently of the centre and had to be closed down. But crucially, the fund took the step of clearing up the Volgograd city insurance system through the creation of a city-wide filial. It used the vacuum of authority created by the corruption of the system to assert its authority.

Shortage of funding

The shortage of funding does not exert simple pressure upon the system to get rid of one or other of the funds and insurance companies. The shape in which shortages come severely disadvantages insurance companies over the territorial funds. A shortage of funding is expressed not simply in less money, but a network of region-wide debts, where everyone owes money to everyone else. There are two ways of solving these debts. Firstly the regional authority can issue "vekselya", notes of debt that operate effectively as money between organisations. Secondly the federal fund has allowed since 1996 the practice of "vzaimoraschet" (inter-accounting) within the compulsory insurance system – whereby debts owed by employers to the fund can be passed onto the hospital (owed money by the fund) in the form of goods in kind – which may be used (such as food), or as happened both in Volgograd and St. Petersburg, the energy companies continuing to supply cash-poor healthcare institutions. According to the territorial fund in 1999 about half the budget is made up in these two ways, the rest in money. It was remarked that "this isn't such a bad situation. In Kemerovo money occupies only 15% of the budget". While the territorial fund is able to manage these debts on a more global scale, individual insurance companies will find this much more difficult. Given that IMO employees are of a more entrepreneurial frame of mind (Grishin 1997), they may find this lack of resources an incentive to move into other fields.

Secondly, as considered above, the lack of funds makes the execution of medical audit more difficult for the IMOs. The point here is not that the fund would pursue *ekspertiza* with any more acumen. The evidence that there is suggests that the IMOs are superior in this respect. But not only is *ekspertiza* not the main task of the fund, its unpopularity with medical staff means that it would not necessarily be missed.

Initial incompetence of medical audit

As we have seen previously, even in St. Petersburg, which has fewer financial problems and a better developed insurance market than most of Russia, not all the insurance companies

seem capable of performing their main task, even in the eyes of a friendly territorial fund. In Volgograd the situation was of course worse.

What is crucial about this for the fate of the insurance companies is that the main contact they have with the medical profession appears to be vindictive and intrusive (medical audit itself was an innovation for Soviet-trained doctors) and in the initial stages inevitably poorly performed, with certain confusion between the economic and medical aspects of the audit. While there is no evidence that the *ekspertiza* done by fund filials should be any better, (and with the Volgograd Fund clearly pursuing a "deterrence strategy"), any fund wishing to bypass insurance companies will gain support among medical workers. Crucially, in St. Petersburg the fund does no direct *ekspertiza*; it is not in a position even to replace the IMOs cosmetically.

Relative expendability of the insurance companies

The territorial funds can make themselves indispensable in ways that the insurance organisations cannot. It is easier for them, as a large, financial, parastatal organisation, to interact with and help the authorities with funding difficulties. Already the Volgograd territorial fund helps non-insurance cases such as war veterans and accident and emergency, as well as covering some of the debts of the administration within the insurance system itself. The fund is by no means unique in this. For example, the Tomsk fund is now the "basic, and sometimes only source of funds to support hospitals" (MG 13.8.97/4).

The fund as a monopsonist cannot be turned away. Insurance companies can be. A doctor from Vladimir comments:

> "In the final analysis, the medical institutions are going to refuse to conclude agreements with [insurance organisations], which is already happening. Head doctors are not rushing to renew agreements, in which it isn't guaranteed that there will be full payment for services rendered."
> (MG 30.5.97/7)

In St. Petersburg the fund may take part in non-insurance funding, but generally only as part of city-wide agreed plans, such that the funds are technically within the rightful activities of the territorial fund in helping the development of healthcare overall. There is no particular funding or organisational shortfall into which the fund may step. Furthermore, as stated above the simpler relationships between insurance companies and administrative territories give the insurance companies more authority before institutions whose own chiefs have appointed that particular organisation as an insurer. The role of insurer of last resort is also not the fund, but the state municipal insurance company.

The desire for order and control

As noted throughout this thesis, respondents express the need for a *vertikal'*, a clear line of authority. There seems a preparedness on the part of many to submit to a clear authority even if it is unaccountable. This view has been sponsored by, among others, Tsaregorodtsev, Russian health minister 1995-6, who considered there to have developed too many insurance companies; he suggested some handing their functions over to the territorial funds (MG 29.3.96/4). Partly the need for a clear authority is practical; partly it is ascribed to a cultural desire. (We can recall the ex-military head of Petrodvorets health, who, ascribing "Soviet mentality" to himself stated, "Not until my generation passes from the scene will things get better"). A fuller version of the quotation at the top of this section by the Deputy Director of the Volgograd fund illustrates this point:

> We have come to the conclusion that the current system of insurers – it isn't good, it's a superfluous link. Maybe it's to do with our mentality, that we haven't got to market relations yet.

The absence of a vertikal' can be produced directly by the effects of the law on local self-government. However, the insurance companies cannot replace this structure, regardless of their effectiveness in improving the quality of health care. In circumstances where across the whole country there is a shortage of money (and where in most places, funding is now historically low), whatever contextual contributions there may be from insurance companies to the healthcare system could quite easily (and understandably) be neglected.

All of these factors suggest that should there be a imbalance in the system, or financial shortages, or indeed simple conflict between the territorial fund and the IMOs, given that the territorial fund in many regions performs many of the functions of IMOs (which itself may lead to conflict) the IMOs may or indeed will be pushed out of the system.

Conclusion

Insurance Medical Organisations have suffered from many obstacles in their development – under-regulation, incomprehension and resentment from medical personnel, corruption, economic uncertainty and, most importantly, chronic under-funding – all in addition to the difficulty of establishing good practice. Their ability to effect change in the health service through rationalising resources, monitoring practice and directing investment has been severely compromised. Reports from the two sites suggest that in Volgograd the productive insurance principle complicates governance through IMOs, and weakens their ability to

develop local health services. Furthermore, broader problems in health policy co-ordination there threaten to sideline the insurance companies as unnecessary links in a complex system. In St. Petersburg IMO function has been more clearly established in its interactions with municipalities, allowing for them to develop reform strategies for the health care facilities over which they range.

Territorial funds, conceived as a corrective and to provide guarantees for the health insurance system, can, because of the filial system of insurance, play ambiguous roles that threaten to undermine that system. St. Petersburg, by introducing a municipal insurance company, has avoided this ambiguity. It is within the power of territorial funds, should state oversight be weak or fragmented, to exert broad control over health care financing to the detriment of accountability and microeconomic efficiency. In many cases this may be necessary to bring order to the health system, in others it may simply be empire building. In Volgograd Oblast' these two are fused in a different conception of health insurance on the part of the fund to that intended by the law. Health insurance in Russia interacts with laws on decentralisation of state property to create a system that has tendencies to imbalance. Crises in regional governance can result in chaotic development of insurance companies, corrective actions by funds that, in being *ultra vires,* undermine the authority of insurance itself.

The relationship between these two insurance organisations (and Russia is unusual in having two links in the health insurance chain of finance) contributes greatly to the dynamic of health care development. It is through the actions of the Fund – some deliberate, some necessary – that regions will follow more marketised, more étatised, or more confused systems of health financing.

9. Russia-wide analyses

From the previous chapter there emerged a set of possible reasons and factors determining the development of health insurance in the federal regions of Russia. Although the initiative in system design in both sites was attributed to the leadership of specific individuals and groups, the subsequent stability and adaptation of the systems was also related to local conditions outwith the immediate control of those governing the health system. In particular:

- the wealth of the region and of regional state finance (and the subsequent affordability of systems involving both links of territorial funds and Insurance Medical Organisations in the chain). This was identified by the health ministry as the main reason for variable and incomplete implementation of the law (MG 28.2.96/3);
- regional and local government structures, in particular the ability of health care officials to exercise control and co-ordinating functions where there is an disjunction between constitutional responsibility, ownership of institutions and fiscal ability; and
- predominant regional economic activity, in particular the effective insurance coverage and monitoring of agricultural areas, and the stability of insurance companies dependent upon (and often deriving their initial capital from) enterprises in the context of economic restructuring and financial liberalisation/destabilisation.

However it is also important to consider active strategies, in particular either resistance to or subversion of the originally prescribed system of filial-free IMO-administered insurance, or its active pursuit. Important here is the rhetorical and practical fragility of the IMOs: their ideological novelty, potential tension and competition with the territorial funds, their maintenance in a shortage economy, their appropriateness in certain regional economies, and issues of corruption and incompetence. In this chapter I seek to examine some of these factors across the whole of Russia. I initially use testimony largely drawn from *Meditsinskaya Gazeta* to support broad findings from the interviews. Having established some hypotheses, I use data from a variety of sources, to examine how far these factors may be important, using the typology of regions derived from Kravchenko (1996a, 1996b, 1998) and Raison (1998), examined briefly in chapter four.

The reason for and rationale of regional system variation have been debated both in the regions and at the centre since the introduction of health insurance. Commonly the question is whether there should be a single model across the whole of Russia, or to allow

adaptation to local conditions. As we saw in Chapter 5, the approach of the central health ministry to this problem has varied with the minister. From 1992 to 1998 there were six different health ministers (and a seventh in 1999). Although the first two demonstrated little interest or support for health insurance (Vorobyov simply ineffective, Nechaev on the make), the diversity in the regions that had resulted from this lack of central guidance became the direct focus of the ministry. Ministers had alternating views: Tsaregorodtsev was more inclined to allow regions to follow the pattern most suited to them, while his successor Dmitrieva favoured a greater assertion of uniformity for the sake of governability and establishing best practice. Rutkovskii, following after her, favoured region by region improvement, while his successor Starodubov was more inclined to establish a single model. Of course, the extent to which an inactive and ineffective central ministry matters to the regions is debatable, as Dmitrieva has admitted. But such arguments at the ministerial level surely reflect general concerns within the policy hierarchy.

The models revisited

It is worthwhile here reflecting again upon the nature of the models that Kravchenko and Raison present. From the discussion of international practice in chapter 4 we can see the extent to which they represent substantively different approaches to health insurance. Model I involves only the insurance companies acting as insurers – the case in 14 regions at the time of the data trawl. This model presents us with a clearly defined distinction between territorial fund and insurer. The fund representative in St. Petersburg suggested this produced greater independence in audit, and formal disinterest on the part of the fund in the well-being of any particular insurance company. Furthermore, no insurance company would be in competition with any filial; one might therefore expect a more open insurance market because of fewer arbitrary obstacles put up by the fund. The greater competition between insurance companies would suggests a more thorough, competent and widespread application of medical audit, and a wider range of medical services under most available insurance packages, given that audit and service package are the main elements of competition between insurance companies who cannot compete on cost. However, with the exception of St. Petersburg where the productive insurance principle is not in operation, the fragmented purchasing power of the IMOs may undermine improvements in efficiency of care that are of financial detriment to hospitals; preventive programmes may have lower priority also. Of course these speculations are necessarily tentative; one cannot assume fair competition in insurance.

Model II involves only the fund filials acting as insurers. This implies that either insurance companies have generally failed to form or have been excluded from the system either directly or through their non-licensing. There were thirty-two such regions in 1998. There is no competition between insurers. Any competition would be between health care providers for the funds from a central monopsonist – in accordance with the vision of the Volgograd territorial fund. It also suggests ceding local authority control over health care institutions to a semi-autonomous fund. In turn this implies greater influence by the Moscow-based Federal Fund, although regional authorities will still have formal control over the board of the fund. Those responsible for administering health in the municipalities will therefore be able to exert less influence over the day to day management of the service, as they will neither have leverage over the filial with which they contract, nor useful influence with city and/or regional authorities. It suggests medical audit of a lower quality than in model I, as well as a more minimal package of benefits given that there is no competition between providers. However, as it restores geographical integrity of purchasing and thus some effective regional-level planning, it may be able to achieve greater alterations in efficiency. The extent to which that can usefully be achieved in a country in which, as respondents have commented, the division between personal and formal relationships is not always observed is another matter.

Model III is a mixed model. In these thirty-seven regions both insurance companies and filials act as insurers. This implies uneven coverage by insurance companies that necessitate fund filials operating as insurers. As discussed in the previous chapter this model may be dynamically unstable; the insurance companies can in certain areas be in direct competition with territorial funds that also create many rules governing IMO operations. Furthermore, the duplication of insurance functions by filials and IMOs may lead to demands for filials to operate exclusively. It also implies uneven and variable governance of the system within the same legislative territory. At times the Russian health ministry has expressed a preference for this model in areas where there is a mixture of agricultural and urban areas: filials should cater for agricultural areas whose dispersed population and health care infrastructure supposedly makes it less practical for insurance companies to operate. The significance lies in the fact that those areas without insurance companies would then also be those with traditionally poorer coverage and quality. Filial structure can of course vary from a large number of small ones, or a small number of large.

Model IV is called the "conditional" (*uslovnaya*) model by Kravchenko, which I have called the administrative model. In these six regions the fund is used as an instrument by regional health care administrations to reimburse hospitals for care, but there is no

separation between fund and insurer, even organisationally. Numbering six in total, most of these, states Twigg (1997) represent deliberate local resistance (expressed by regional leadership) to the federally-determined law, although on what this judgement is based is not indicated. As this fourth model represents relatively rare but substantial non-compliance with the federal law to the extent that most of the arguments derived from previous chapters regarding alternative systems do not apply here, it is excluded from the subsequent analysis.

Conceptualising choice: governance and markets

The 'choice' of model comes down to two issues: the priorities and outlook of the regional administration and the feasibility of a model in given circumstances. Inevitably, distinguishing between choice, compulsion and expedience in policy is empirically difficult; policy-makers are wont to rationalise processes of "muddling through" (John, 1998). Those regions employing model I may be doing so because they have actively pursued the opportunity to marketise health, or because they have more passively fulfilled federal legislation, or had their hand forced by employers and municipalities seeking to exercise their legal right to insure with whomever is licensed. Those excluding or crowding out IMOs for Model II may be against pluralised insurance ideologically, or have felt it was in appropriate for their socio-demographic or economic conditions, or had difficulty as a region establishing an IMO market. A mixed model can be either of institutional conflict over insurance, or of unsuccessful attempts to establish fully the legislative model, or indeed may reflect variation of conditions within the region, with IMOs operating in the bigger cities and filials working in rural areas.

A brief analysis of these explanations/rationalisations of regional strategy reveals a dominant concern with governance and the governability of health. If "governance" is a matter of the disaggregated state seeking to "steer" policy in a more pluralistic setting rather than administer directly (Rhodes, 1997), it is clear that such a process is exemplified by the 1991/1993 law. Politicians and bureaucrats whose operational experience has been within the communist command system might easily be wary of such forms of governance. State responsibility and accountability are made fuzzy (officials at all levels of local government have more independence, while the top of any chain of command has effectively been devolved from the centre to the federal region). The new situation can also easily appear unnecessarily complex.

As respondents in both regions of this study explained, the loss of a governing vertikal' was both problematic in practical terms and in terms of "Soviet" psychology. Many in charge of health care financing and organisation in those regions where IMOs are

dispensed with state that such concerns have underpinned their strategy. For example, echoing concerns raised by the chair of health care in Petrodvorets, St. Petersburg, there are those who consider the lack of direct state control contrary to state obligations to guarantee health care:

> "We assert [otstaivaem na] the priority nature of the state health care system, and so therefore were against the first variant of the law on medical insurance, which proposed the direct handing over of contributions to the IMOs, who in the majority would be private. In such a way, the state would in fact have refused its constitutional duties and responsibilities in the provision of accessible, qualified medical help to the population and the health protection of citizens... We are for medical insurance, but only a rational (razumnoe) version.
> MG 20.9.95/4 Interview with chair of health care committee N. F. Gerasimenko, Altai Krai

> [in referring to the "reckless introduction" of medical insurance] Recently I was in Troitsk [second city of the region] and became convinced that as yet the strength and merits of the current system are based upon and are maintained by state financing.
> MG 12.10.94 Interview with the deputy head of health with responsibilities for insurance medicine, A. Vladimirtseva, Chelyabinsk Oblast'.

As with respondents, administrators in other regions find "governing through governance" problematic to conceptualise and operate. The director of the territorial fund in Komi republic, which has no IMOs, asserts the need for two strict *vertikali* of finance and administration "from Moscow to Syktyvkar" (MG 21.11.97/6). The director of a fund filial in Krasnodar Krai (where there is a mixed model) talks of the legacy of Soviet governing methods:

> We have always succeeded more in administratising than in common sense... The current decentralisation re-orientates governing structures towards different functions – from the administrative to the co-ordinating, analytical and others, for which not every manager [rukovoditel'] is prepared." (MG 30.9.94/6)

These suggestions of psychological unpreparedness within administrations are common across the regions

By contrast, officials in many of those regions who use the pluralist model of health financing tend to conceive of the IMOs as being part of a governing structure, rather than the subject of governance, just as in St. Petersburg the fund representative clearly asserted the embeddedness of the IMOs within the system. In Novosibirsk, just as in Petersburg, insurance companies are being used by the fund to pilot new methods of financing and provision (MG 15.12.95/9). In Novgorod Oblast' the head of health care even talks of the chain of fund – IMO – health care unit as a good *vertikal'*, that provides good transparency (MG 8.4.98/3). As in the two sites, the imperative of marketisation may be over-riding other concerns. The head of health care in Tver' Oblast':

> I understand that without the IMOs the compulsory medical insurance system would be cheaper and easier to manage. It's possible that the funds could become monopolists as insurants. But if we are serious about having market relations in health care then we cannot do without the IMOs. (MG 15.5.96/4)

Attitudes to the chief function of IMOs - medical audit – are also illuminating. In Moscow Oblast' as in St. Petersburg, the Fund welcomes the independence of the IMOs from both the state and from health care institutions in their exercise of "objective" analysis of treatment. In other model I regions, such as Stavropol' krai, problems with the exercise of medical audit by IMOs are seen as teething problems (MG 27.5.98/7) rather than indicating fundamental flaws in the system. Typically in those regions where insurance companies are largely or exclusively active in insuring the population, cases of incompetence are treated individually; emphasis is placed upon corruption and incompetence throughout the system (*i.e.* the IMOs are not exceptional). That is, they are not scapegoated.

By contrast, the Rostov Oblast' fund, just as its neighbour in Volgograd, appears to be pursuing the ultimate elimination of IMOs from the system, both evidenced by its publications (cf. Kondratenko 1998) and by the express desires of some of its officials (MG 12.2.97/4) to absorb these functions into the functions of the fund. In Ryazan' the "problem" of various companies exercising uneven medical audit is classified by some senior officials as an issue that threatens the operation of the system (MG 31.7.96/4), while in Kalmykia IMOs simply "aren't necessary" (MG 17.7.98/7-8).

Of course, there are other issues affecting the choice. The two most dominant from across Russia are, according to those who see the exclusive use of IMOs as insurants problematic, cost and the problem of insuring agricultural areas. Again, these are two issues (especially the former) that were also raised by respondents in the study, especially the first, and especially in Volgograd. For example, it is argued that IMOs complicate matters both "financially and administratively" (Ryazan', 26.9.97/3 special issue; also Bashkortostan 1.4.98/6); life without them is cheaper and better suited to the special conditions of the North (Komi 2711.97/6), in both Kalmykia and Kursk Oblast' (12.8.95/5) the dispersed agricultural population is said to need guaranteed insurants in the form of fund filials.

In general we can understand the regional variation in the following manner: the mix between IMOs and filials is a function of (a) the viability of IMOs (b) support for IMO structures; and (c) the necessity of using filials (because IMOs do not arise or achieve full coverage). As an example, in Volgograd Oblast' while IMOs were supported initially and flourished, they have latterly been squeezed out because of increasing financial shortages and a more assertive and *dirigiste* fund; it was the opinion of some respondents that IMOs

were not appropriate for outlying regions. In St. Petersburg, IMOs were certainly viable because of the large amount of capital and healthier financial infrastructure, certainly supported by liberal governing structures under Koryukin's leadership, and with a geographically dense and wealthy population they were capable of insuring all citizens. Of course, the territorial principle made full coverage with IMOs easier to guarantee. The rest of this chapter examines which factors prove the most influential across the regions of Russia.

As a statistical note, given the relatively small number of regions (between 70 and 83 depending upon the data sources) and the nature of some of the data (categorical as opposed to continuous), in many cases statistical significance tests cannot be applied, especially where one seeks to control for variables; where it can be applied the result is stated.

Is there a single Best Practice?

Part of the central ministry concern about model variation is whether one model is obviously more effective than others in funding and improving health care. Those opposed to the use of IMOs frequently refer to their cost as a "superfluous link" [*lishnee zveno*] needing maintenance in the chain of financing. In Volgograd Oblast' the fund's rationale behind the sidelining of the IMOs was to save money, and respondents commonly argued that either one of the IMOs or the fund should be dispensed with. Even the head of the All-Russia organisation of insurance medical organisations conceded the "thesis, that the funds and the insurance companies get a large percentage of resources for their own upkeep." (MG 7.7.95/4), and relies on arguing for the economising dynamics of the IMOs.

It is of course difficult to assess how well insurance medical organisations have been able to exercise any economising function when prices are usually set by the region, and where inter-regional figures for medical inflation are not available. Furthermore widespread under-funding (low contribution rates and low collection rates) means that money saved will not be reflected in lower health care expenditures, but in improved hospital funding up to what the norm should actually be.

Kravchenko briefly considers the ability of each system to achieve full coverage and to direct money towards health care. Federal fund data supports the idea that systems dominated by fund filials do pass on a higher proportion of money *that is collected* to health care institutions. However, the level of insurance revenues also varies across regions. Although in terms of collection, health care contributions and other social taxes have first call on the wage fund of companies before other items of taxation, to be subject to contributions in the first place, an employer or a local authority needs to have concluded an

agreement with an insurer – be it the fund (or a filial) or an IMO. According to federal fund data, coverage is best achieved where insurance companies are working. Therefore with IMOs there are more contributors, and thus more money flowing into the system in the first place. Kravchenko suggests that territorial funds and their filials experience difficulties ranging over a wide area. However, insurance organisations, with fewer resources than the overarching fund, would likely suffer from similar problems if the population they cover is dispersed over a large area. A more likely reason seems to me to be the greater self-interest on the part of the IMOs, in competition with each other, to conclude agreements to secure their income. Furthermore, using data gathered by Korchagin (1997) on various levels of contributions gathering and expenditure in each region to calculate averages for each model, it becomes clear that IMO dominated systems tend to gather more revenue both from employers and from local administrations. This result again suggests that it is simply not a question of being able to range over a wide area, as local authorities will tend not to be particularly inaccessible.

Furthermore, it is clear that the IMO dominant models' ability to gather money appears to cover their operating costs: in 1996 they provided, on average 10% more funding for health care than those models where filials dominated, with mixed models lying almost exactly in between them – even after adjusting for the higher prices in each region[1].

There are two other explanations for this difference in the ability to gather funds – that, following Kravchenko, the regions with the IMO dominant model are more dense in population (which coincides with concerns about the viability of the legislative model in sparsely populated agricultural areas), or they simply are wealthier.

The hypothesis – that there is a link between density of population and IMOs controlling expenditure – is not supported by any significant correlation. Another version of the same argument, containing an element of prescription, produced by representatives from the Kalmyk republic – that with small populations, one can "make do" without the insurance medical organisations – is also not proven by the data. There is, however, possibly a stronger link between small populations and being less well off as a region, although again the statistical significance is not very high. A third version of this argument put by Duffy (1997) is that the insurance companies will flourish in big cities more than elsewhere. Examined below, this proposition has some weight. However I argue that this has less to do with a large

[1] Korchagin provides data for expenditure region by region; the price adjustments are general price indices, as price differentials in medicine are not available. Price adjustments tend to bring the models closer than using nominal expenditure figures, indicating significantly higher general level of prices in those regions with more IMOs.

city population per se, but that the more large cities there are in a region, the more likely it is an insurance market will be supported.

There is certainly a statistically significant link between regional wealth, as taken from Goskomstat data for 1996 and 1997 and the choice of system model, which I examine further below. The question then becomes – is there a difference in the amount of money spent on health care once we take relative regional wealth into account?[2] The data suggests there is only a mildly positive connection between health expenditure and the extent to which IMOs are involved. If one takes inflation-adjusted figures into account, this difference even reverses, although the inflation adjustment itself is rather problematic.

What is important is that there is no strong evidence either way that the IMOs are overall more costly as a means of funding health insurance – that whatever administrative cost they do impose may be more or less covered by increased revenues going into the insurance system health care. In other words, for want of more detailed data, it seems IMOs probably have overall a neutral effect on revenue going into health. However, based on the interviews and other qualitative evidence, we must note the *perception* that the IMO dominant model is more costly does seem to influence policy making in many regions.

Characterising the models politically

As already stated, any choice of model can be seen as a reflection on the acceptability of pluralist non-dirigiste solutions to problems of state function. One might wish to see Model I as typifying the approach of the liberal pluralist, and model II as statist. Indeed, the interview and other qualitative data support the notion that the health insurance project is part of the pro-market liberalising project. At the beginning of the field research, it was decided to ask respondents about the relevance of elected officials to the development of the medical insurance system. This was prompted by the importance granted in the West by aid agencies (Lloyd 1997), governments and media to the election of "reformist" (i.e. non-communist) figures, who could be trusted to enact policies more agreeable both ideologically and economically to Western political forces. In addition, Shishkin (1995) suggests both conservatives at the centre had been disrupting implementation and that active regional government support was key to success in implementing fully plural health insurance - both in IMO formation and the development of a legal framework. Other researchers in Russian health care have given importance to the political sphere, and echoed concerns that the political system both was unable to express population preferences in healthcare, and that the

reformist movement in Russia was being limited to a few major cities (Duffy 1997). "Reformist" in these contexts clearly meant moving towards a market economy.

The first thought must therefore be that more conservative regional regimes, where communists and their allies have been elected or are in power, will more likely prefer not to operate with insurance companies in health financing. As noted in previous chapters, some respondents implied or explicitly stated that opposition to the reforms in healthcare financing was conditioned by a "Soviet' mentality: people who hadn't adjusted to the changes in society, including one case of self-reflection.

When asked explicitly about the importance of elected administrative officials for health care policy however, no respondents considered them important in initiating change or reform. The only influence that seemed to be exercised by politicians overall was the legislative gridlock in St. Petersburg and the inactivity of the Volgograd Oblast' Duma in taking any decisions whatsoever. (The exception is the alleged politicking that led to the removal of Koryukin from the City Committee Chair in St. Petersburg – a once and for all act.) It was commonly related that health care was mentioned during election campaigns but was of little specific relevance to health care in practice after elections took place.) Problems with "Soviet mentality" were seen as endemic rather than a function of regime leadership.

In spite of these statements (and indeed, *because* they are contrary to the concerns raised above), it is still important, given the emphasis of much of the literature to consider whether there is a connection between politics and health insurance development, considering the whole of Russia.

In considering regional data on political tendencies, it is important to understand what we can usefully measure. To begin with, the majority of regional heads between 1993 and 1996-7 (during which time health insurance was implemented) were appointed by Yel'tsin in the aftermath of the 1993 attempted coup, in order to stifle regional opposition to his leadership. Furthermore, Russia-wide data gathering and analysis of local (sub-regional) elections of officials – perhaps better placed to foster or resist health insurance – was not possible within the scope of this study, even more so the persuasions of appointed officials.

However it is important to remember that the Yel'tsin appointees were often a compromise between loyalty to the centre and acceptability to local elites (appointees were usually one of a set of nominees by the regional soviet (Stoner-Weiss 1997). Local preference would have exercised some influence over the general tenor of policy. In

[2] The Goskomstat figures I have used are the regional percentage share of the Russian economy and the population, with the former divided by the latter to give coefficients that can account for the

considering the elections for regional executive in 1996-7 we can establish what coalition of forces holds sway that enables the victory of reformist or conservative candidates (acknowledging the nature of Russian local politics). For general political outlook of the population (which we can suppose may say something about lower-level bureaucrats) we can use as a proxy the voting patterns in the 1996 Presidential election.

There are a number of complications in classifying the political tendencies of an administration or a region or a candidate. One can be pro or anti-"reformist", pro or anti-communist, liberal or statist, pro or anti-Yel'tsin, authoritarian or democratic. Within the communist party and its allies, for instance, there are clear socialist, Stalinist, nationalist and social-democratic tendencies[3]. Furthermore these general political divisions are shoe-horned into a bi-polar choice by the electoral system, which is two-stage as in the French presidential system. Furthermore, in common with French personality-based electoral politics (where parties were formed commonly for the electoral support of and around specific people – de Gaulle, Giscard d'Estaing, Mitterrand), many of these labels are also indicative of candidates' allies and bosses as well as their policies. Official labels are ultimately an approximation. Again, deeper analysis of political platforms is outside the scope of this study.

However we can turn these problems to our advantage. The question of politics was put because of the importance placed by the media and western politicians and financial agencies upon the quasi-official membership or otherwise of the "reformist" or "communist" tendencies of certain politicians in "getting reform done". This bi-polar "them and us" approach (which sometimes leads to arbitrary distinctions, including the variable treatment of Nationalists, militarists and social democrats) is often expressed in support for either the Kremlin parties of power or for the Communists, and it is precisely the importance of these labels that interests us.

Ultimately, for neither set of electoral results was there any particular connection – supporting the views of the respondents – with the exception of a strong link between a tendency to vote for the social-liberal Grigorii Yavlinskii and his Yabloko party candidates and the dominance of the first, most pluralistic model. Those populations with the first model are half as much again as likely to vote for him as in model II, with model III appropriately coming somewhere in the middle. However, as he gathered no more than 5 and

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relative wealth of each region.

[3] Indeed, Hillel Tickten in his review of a book on Left parties in the former communist states remarks that "Zyuganov' s party is considerably worse than an opportunistic party that co-operates with the government at certain times and criticises it at other times. It is not just a party which pretends to be left-wing and socialist to its grass roots but managerialist and pro-market to its capitalist and managerial supporters. The party is anti-semitic and semi-fascist in its orientation." (1999: 171)

10% in elections in the 1990s, this connection shouldn't be dwelt upon as an indicator of ideological influence over policy, and may be simply be a function of the same liberal economic factors underpinning both (the numbers are too small to separate the connection statistically). Given that other writers have stressed the importance of regional government resistance and enthusiasm for health insurance, are there other indications of what might form this resistance?

Beyond labels

An alternative approach to the question of general political control is to ignore party labels and consider the substance of general economic policy in the regions. Ulyukov (1998) analyses the "liberality" of the economic policy of regions across Russia using six different indicators (price controls, use of subsidies, the openness of local markets as determined by tariffs, housing and property reform, the level of taxes on profits and the centralisation of budgeting.). These indicators represent key pillars in orthodox reform economics – deregulating, opening and marketising economic life. There are, of course, problems with accepting this analysis, notably the relative weighting given to each item within the overall ranking can always be disputed. Furthermore, there are problems even with Ulyukov's neutrality; he is not only avowedly an economic liberal (liberal economics for him is the key to economic growth), he also identifies poor and underdeveloped regions, including the autonomous republics with their "easy to manipulate electorates" as belonging to the "red belt" (which stretches north south, and commonly includes Volgograd), that votes for Zyuganov and nationalists in various parliamentary and presidential elections. However, if one looks at the relationship between political allegiance and economic policy, there appears, with all the statistical caveats necessary with numbers this small, to be *absolutely no connection* between the winners in regional elections and economic policy on Ulyukov's analysis. This would lend support to the finding that political labels connected with outright support or opposition to the Yel'tsin have little connection with actual health care policy.

What are the possible implications of possessing a more "liberal" economic policy? One would expect a more open economic policy to encourage more IMOs: there would be more developed licensing practices; capital would be easier to acquire to start up an IMO, and possibly the principle of markets in welfare may be more accepted. Conversely, in those regions where there has remained greater state control over the economy, there would be a preference for maintaining simpler quasi-state control over financing of health care.

As we can see from table 9.1 there appears to be a clear connection between liberal economic policy and a preference for the "legislative model" of IMO health insurance[4]. Although this model accounts for one sixth of the cases considered here, it includes over a third of all those regions he labels as liberal. However, there is a far weaker connection between illiberal economic policies and the pursuit of what seem to be more statist solutions. This suggests that the ideological explanation may not be as powerful as the practical one: it is in those regions that have pursued liberal economic policies that insurance medical organisations have found it the easiest to flourish; in other regions there appears to be no deliberate avoidance of IMO markets. Indeed, the disjunction between the political colour and the economic policy of a region suggests a less dogmatic approach to reform[5]. This supports both the finding that political/ideological labels are not important, and also the reflection by Shishkin (1995) that it is passivity and inactivity that has dogged the full implementation of health insurance rather than hostility *per se*.

Table 9.1. System type and economic policy

			Economic Policy			Total
			Liberal	Moderate	Illiberal	
System type	IMO model	**Count**	5	5	4	14
		Expected Count[a]	*2*	*10*	*2*	
	Filial model	**Count**	3	22	7	32
		Expected Count	*4*	*23*	*5*	
	Mixed model	**Count**	3	31	3	37
		Expected Count	*4*	*27*	*6*	
Total		**Count**	10	60	13	83

Data sources: Kravchenko (1998), Ulyukov (1998)

[a]It should be noted that these figures have been rounded to the nearest integer.

Another finding is that illiberal models have fewer mixed models than expected. What one might take from this analysis is the notion of "purposeful" regions. In *Local Heroes* Stoner-Weiss (1997) attempts to understand why some regions have more coherent policy than

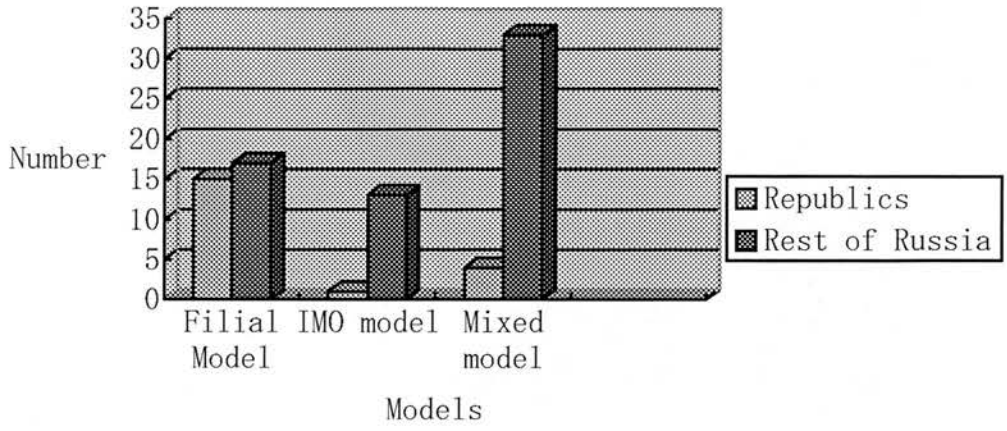
[4] Because of the small number of cases, performing statistical tests such as chi squared *etc.* is not possible in the majority of relationships analysed in this chapter.

[5] To complicate matters further, it has been documented how across former communist countries allegiance to the rhetoric of reform and to the substance of it have been only loosely connected in the wider population (Mason 1995). Thus there may be ideological pluralist members of the communist party and other left-wing groups determining policy.

others. She considers the notion of "policy output" as a measure of governmental performance (with equal respect paid to reformist and conservative strategies), and finds that the more corporately coherent governments are able to achieve more effective policies. In considering the significance of distinctly liberal or illiberal policies, we are considering in part the purposefulness of a regime in pursuing a distinct set of policies. While on the one hand liberal/illiberal are opposites, they are, in this context, both the opposite of average. Choosing between having IMOs or not having them at all is evidence of clearer choices than allowing for a mixed system of funding to develop. After all, in Volgograd Oblast' the mixed system arose because of the inability of the Oblast' or of the Territorial Fund to exercise authority over the constituent parts of the system. Thus it may be the case that some regional governments are more able to assert their policy programmes than others – whether that is the IMO dominant or the filial dominant system. Health care is simply one part of that purposeful approach. The influence of economic concentration (which for Stoner-Weiss is key to establishing clear policy) on the development of health insurance is considered below.

There is also indication that where it is easier for regions to act independently of the centre – in the republics – they tend to pursue more statist solutions. As noted in chapter 3, although Russia's regions are according to the constitution equal, the republics have tended to enjoy more autonomy. As well as being able to indulge in greater independent activity with foreign countries, they also reach agreements with the federal centre on the extent of their autonomy within Russia. This includes relationships with the federal compulsory health insurance fund. These areas are notable both for their electoral support in the 1990s for Yeltsin over the communist alternative, and for the more statist (some might say dictatorial) regimes by which they are governed. One might therefore expect them to favour less plural solutions. Indeed, in figure 9.1 we see clearly that the republics, although implementing the federal insurance law in some form (only one of the six "administrative models" are from the republics and that is, unsurprisingly, Chechnya) they have tended to choose the more statist model. In one case (Tatarstan) they have sought to make insurance money even more in control of the health department through the system of *bol'nichnye kassy*.

Figure 9.1 Health insurance model and federal subject status



Data Source: Kravchenko (1998)

The Economy

As foreshadowed above, while there appears to be no objective reason for poorer regions to reject the IMO model on grounds of cost, there is a significant positive linear correlation between the proportionate level of IMO activity and the per capita wealth of the region (data sources: Kravchenko 1998; Goskomstat) to the 1% level, (correlation co-efficient of 0.292). However, the expense of the system is only one aspect to consider. There are at least three other ways in which wealth helps in the development of insurance companies within compulsory medical insurance.

The use of audit. Apart from the perceived cost of maintaining IMO structures, one also needs to consider the legitimacy of a system of independent monitoring. Where resources for health care are chronically short (and morale also lower), medical audit may seem a luxury, and any system of fines bordering on absurdity. Resentment from health care structures is bound to be more intense.

The availability of capital. Richer areas are more conducive to the creation of Insurance Medical Organisations. Not only is there likely to be more capital, but there will have been more chance for IMOs to develop as voluntary insurers (which was the original plan) in the period between 1991 and 1993 before they took part in compulsory insurance. This certainly occurred in St. Petersburg and Moscow. The interview data from St. Petersburg suggests that IMOs engaging in voluntary insurance may not wish to tackle

compulsory insurance, as it is less profitable; however, they still permit the development of health insurance regulation and practice.

The degree of monetisation and the strength of public structures. Richer areas are more likely to be able to sustain IMOs. This is not simply that the 3.4% contributions will be higher. It is also the case that in richer areas there will be less need for the bartering within the health system that took place under the inter-accounting process of *vzaimoraschet.* Richer regions will tend to have more cash in their system and not need to operate using the system of promissory *vekselya.* So IMOs in richer regions will not simply receive more cash in line with the wealth of the region, but will avoid problems of non-payment, or payment in kind (they will also be in less of a position to co-ordinate payments in kind between organisations). It might be argued that poorer regions may have lower public revenues available to insure a larger economically inactive population – whose contributions will be lower than the working in any case. That IMO dominant systems collect more revenue from local authorities may simply be a reflection of stronger public finances. However, the smoke-filled room dynamics of subsidies from the centre to the region (McAuley 1996), the inability of regions to influence their revenues with taxation because of central budgeting practices (Zhuravskaya 1998; Lavrov 1998) and problems with the unemployment figures make this question problematic to analyse with official data.

Beyond general measures of regional wealth, the interview data has suggested that the structure of the economy also significant. From the interview data it is possible to make two hypotheses about the influence on the development of health insurance regarding the economic profile of any one region. First of all, that the greater the level of industrial activity, then the more likely there will be a model containing IMOs. Secondly that there is more likelihood of the use of filials to cover agricultural areas.

The first hypothesis is made for two reasons. Firstly, enterprises are interested in having more control over the money they pay into the insurance system. Payments in kind through welfare measures are part of the Soviet tradition of enterprise employment. Where there is one regional fund and its filials, enterprises will have less control over the medical care available to their workforce. Furthermore, with filials dominating health care funding and in places taking over the funding of non-insurance activities, the connection between payment of contributions and receipt of care inevitably becomes weaker. While the principle of the richer paying for the poorer is enshrined in the different contributions according to income and working status (payments for the non-working are taken as some proportion, initially locally established, of the minimum wage), non-payment of contributions by

municipalities has stretched this principle further than many enterprises wish to go. Even in St. Petersburg, where there was a relatively high payment of local authority contributions, respondents reported that larger enterprises were unhappy with the territorial insurance principle, which, they felt, made employers pay excessively for the non-working. As a result of similar pressures, in some regions the non-working were originally excluded from the insurance system. It should be remembered that employers have a right by federal law to contract with an insurer of their choice (although this right is circumscribed by the licensing powers of the region); in St. Petersburg there were rumours of potential court action being taken against the city authorities. Where there is more industry as opposed to agricultural enterprise, we should expect a stronger exercise of this right.

Secondly, as reported in Volgograd, many insurance organisations started up to cover specific enterprises: the presence of industrial concerns suggests a fertile breeding ground for IMOs. They will also tend to have more capital than agricultural enterprises, and also have tended to have a greater historical interest in providing medical services to their employees as a means of payment. It is true that the development of IMOs at this level has been identified as a source of corruption and inefficiency (if one recalls the "telephone rule" in Volgograd Oblast' which emphasised personal connections over efficient practice in the awarding of contracts to IMOs), but that is another matter.

The second hypothesis that where there is more agriculture there will be greater use of filials is partly the corollary of the first: where there is proportionately more agriculture, there will be proportionately less industry (although other categories such as retail trade and "investment in basic capital" also exist in the goskomstat figures). However, it is also a comment on the nature of agricultural populations – that they experience seasonal income and employment. They are traditionally a difficult population to cover with social insurance and across western Europe the development of welfare states have experienced problems resolved either by special schemes for people in this sector, or, at least in the early years, simply avoided insuring them at all. Furthermore, the low priority of the agricultural sector in health service planning in the Soviet Union: the sparseness and more basic equipping of health care units and the poorer qualifications of many medical staff (some areas are covered in polyclinics by *feldshery* (paramedics) only) makes the operation of an insurance system that is based upon standardised notions of improvements in quality and competition between insurance companies far more problematic. The journeys needed to travel to monitor work are great. The communications infrastructure, which might compensate for this, will be worse. Standardised medical audit is difficult to enforce in cases of broad and chronic underinvestment in areas where finances and enterprises are poor, where there is likely to be

even greater unevenness in service provision between the regional centre and the periphery than in other parts of Russia. These are all reasons by which pluralised insurance medicine is made problematic in its operation. It might actually be said that measuring the level of agricultural production in a region is effectively a proxy for looking at non-urbanisation. However, when one considers the relationship between the proportionate share of the agricultural sector of a region in its overall economy, and the proportion of people in the region living in cities, there is a surprisingly weak correlation between the two (although a much stronger one between industrial activity and urbanisation).

If we consider table 9.2, we see that the first hypothesis is borne out: IMOs are more likely to be involved in health financing in areas with high industrial activity. However, the second hypothesis regarding agriculture is not supported. There is only a mild negative connection between the predominance of agriculture and the pre-eminence of IMOs; much of any relationship that may seem apparent at first appears to be the result of the poverty of agricultural areas rather than the type of economic activity (indeed, after regional GDP is taken into account, there isn't even much of a relationship between agriculture and industry). Urbanisation in itself also does not seem to indicate any advantage for IMOs, once we take into account the fact that urban areas are richer.

Significantly, this result contradicts the commonplace amongst many commentators (including health minister Dmitrieva) that the needs of agricultural areas dictated that pluralised insurance itself was inappropriate. So do we conclude that there is no significant importance of agriculture in the development of an insurance system? Stoner Weiss argues that more pluralistic and diverse economies, as encouraged by liberalising economic reformers, have tended to undermine the governance abilities of local authorities by generating fragmented and diverse demand upon state financial and organisational resources. While I do not have access to figures regarding economic concentration within sectors, it is possible to assess the impact of the dominance of either industrial or agricultural concerns[6] and therefore the extent to which demands on regional government are diverse. We should expect that where a region is strongly agricultural or industrial, there should be fewer mixed models of health insurance, if we conceive of Models I and II as being more purposive. Such arguments appear relevant in the case of Volgograd (with no dominant economic concerns, and with a mixed agricultural and industrial base) it was precisely weak governance of the

[6] The variable for concentration is arrived by calculating the difference between agricultural and industrial activity levels: $\sqrt{((\text{industrial activity} - \text{agricultural activity})^2)}$. (the squares and square roots are used to ensure the result is positive – that either industrial or agricultural concentration produces a high value.)

Table 9.2. Partial correlations between variables (controlled for regional GDP per capita)

Agricultural activity	.0110	*Correlation coefficient*		
	76	*Cases*		
	P= .924	*Probability of no relationship*		
Urbanisation	.1687	-.0189	*Correlation coefficient*	
	76	76	*Cases*	
	P= .140	P= .869	*Probability of no relationship*	
Proportion of insurance Funds going through IMOs	.3415	.0227	.1371	*Correlation coefficient*
	73	73	73	*Cases*
	P= .003	P= .847	P= .241	*Probability of no relationship*
	Industrial activity*	Agricultural activity*	Urbanisation**	

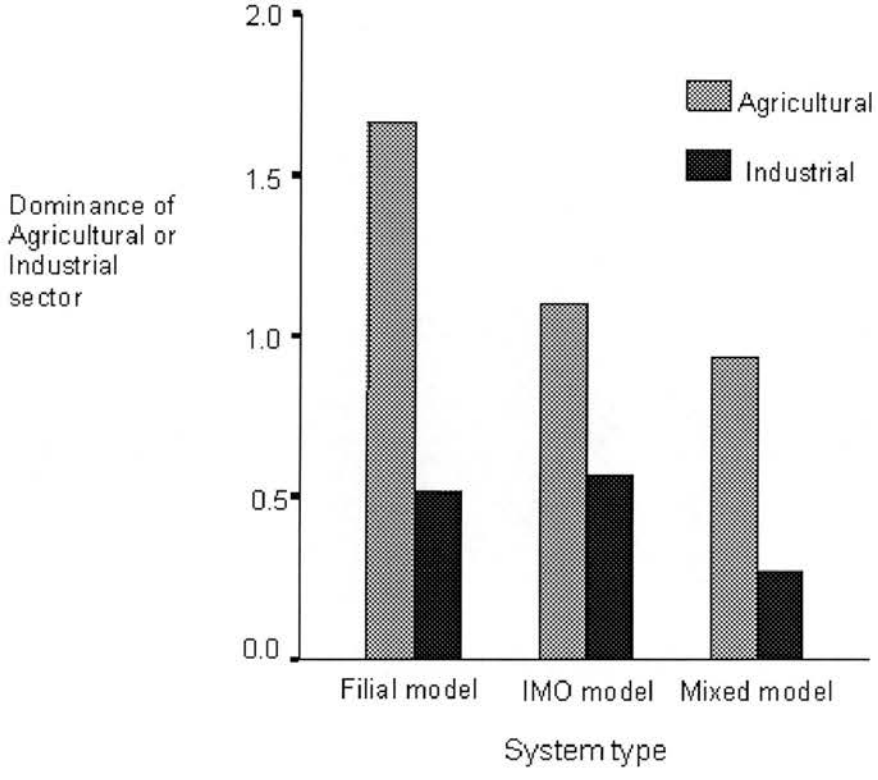
Data sources: Goskomstat figures for 1997; Kravchenko (1998)
*Expressed as the size of the sector in comparison with the local economy as a whole.
**The proportion of the population living in cities of 10,000 or greater.

health insurance system that gave rise to the mixed system. A multitude of filials were working independently of the central fund, and insurance companies were operating under ineffective oversight. Despite the enthusiasm of the working group that worked to create and encourage the IMO market in 1993, the system became chaotic and in need of resolution. The Oblast' executive and legislature were also both accused of inactivity and lack of purpose.

Figure 9.2 bears out the hypothesis, and emphasises the importance of considering the filial model not so much as deviant but as a clear policy choice. Those areas that do not simply have a high level, but a *dominant* level of agricultural activity are more likely to pursue the statist filial model. What may muddy the water in less disaggregated models is

that areas with dominant industrial activity will also tend to pursue the filial model almost as much as they would the IMO model. Thus any relationship between agriculture and a specific model of health insurance appears to be a choice on the part of regional authorities rather than a simple function of agricultural labour markets and funding.

Figure 9.2 Economic Sector dominance and system model



Of course such broad results could be masking a variety of relationships – not only coherence of demands to regional government, but also less segmentation of the insurance field, for example. However, it does at least *prima facie* support a synthesis of the stress placed by other commentators and actors that *something* about certain regimes makes them likely either to obstruct or pursue plural health insurance with vigour, and Stoner-Weiss's theory regarding the coherence and effectiveness of regional government activity. Given the weakness of state structures and their unpreparedness for market institutions following the collapse of Soviet power and the beginning of the "transition", it stands to reason that looking to politics and ideology for indications of regional development of insurance is insufficient: one must look to government that is effective enough to make a choice too.

Local government, regulation and the problems of the vertikal'

In previous chapters we saw how the structure of local government and the distribution and decentralisation of municipal property (including health care units) complicated the operation of the health care system in Volgograd Oblast'. This conflict and lack of co-ordination led to an absence of regional legislation vital to the system's operation (in particular the territorial programme of provision and the setting of prices). It also undermined the ability, in co-ordination with the financing agents (the fund and the IMOs) to rationalise health care resources on a region-wide basis. Day-to-day conflict was evident in funding arguments between the two big cities and the regional authority for health care units under their respective jursidictions.

Part of the problem was the nature and decentralised structure of post-Soviet local politics (one may recall in the previous chapter the description by the Volgograd Territorial Fund representative of local government heads wishing to be tsars in their own land). Political capital was to be gained in the defence of local institutions – often at the expense of regional co-ordination. Economics also mattered. In shortage economies (which are less-than-zero-sum games), distribution systems based upon exchange and inter-accounting commonly lead to resource hoarding and delay in payment. This problem is complicated, as was the case with the larger towns in Volgograd Oblast', when the Oblast' as chief regulator is poorer than the urban centres within it. According to the head of the Volzhskii IMO this led to vindictive behaviour on the part of the Oblast' in allowing Volgograd city residents access to Oblast' facilities (see previous chapter).

All this is expressed as the loss of the *vertikal'* to which respondents in Volgograd Oblast' often referred – the lack of clear commanding authority from the very top to the very bottom ("from Moscow to Syktyvkar"), and the current unfamiliar and sometimes over-complex systems of negotiation and divided responsibility between different levels of government. According to Lyubanovskaya this problem was common across Russia.

> In healthcare the greatest problem is the interaction of the local government administrations and the compulsory medical insurance funds. A huge defect is that in the large city and Oblast' centres there was no provision for the creation of their own funds. This creates a mass of problems in the inter-relations of city local authorities and the Oblast' funds. Many Oblast' funds are refusing to create even city filials of the fund, which leads to regular battles in the distribution of funds, arguments and clarification of relationships. (Lyubanovskaya 1994: 57)

Against Lyubyanovskaya's arguments, the experience of Volgograd Oblast' of having many filials in across the Oblast', (at one point in the mid 1990s, there were 44 filials, with three acting completely independently of the fund) was equally problematic. As explored in

Chapter 6, the fundamental difficulty in Volgograd Oblast' was the disjunction of responsibilities for legislating and regulating authority, financing, and day-to-day management and control. The only solution, to which the administrators interviewed were resigned, appeared to be strengthening the central fund at the expense of local authorities. In St. Petersburg no such problem could have arisen because no tier of local government beneath the regional authority – the city – has any independence.

There are several hypotheses one might want to explore here. The crucial problem is how to get at the real question – what structures of local government make the system more or less workable, and in what form? For this analysis I have excluded the republics, whose governance structures are not so hamstrung by the law on local government, and the two federal cities, as they fall outside this analysis.

One might wish initially to consider the density of the population on the grounds that a more dispersed population represents a bigger co-ordination problem. However, as we saw above there is no such connection between straightforward density and system model. The overall level of urbanisation, which we might expect to make for a population with more homogenised demands, also has no relationship with IMO involvement (see table 9.2 above). Indeed, these measures are too blunt to describe the institutional formation of local government.

What is more productive is to count local government units rather than people. Those regions where model I is dominant average just over three large cities in each (counting a big city as over 100,000 people) as opposed to just over two for the rest. Given that urbanisation is not a factor, it appears that the number of large cities is more important than the number of people actually living in them. That the cities are fairly large is important: a similar analysis using the number of cities over 10,000 produces no such relationship. A possible clue to this relationship can be explained by the interview data and by reference to the problems of the law on local self-government. The Volzhskii municipal IMO representative described the polarisation between the two richer conurbations of Volzhskii and Volgograd (which also were home to many of the specialist and better health care facilities) and the rest of the Oblast' – the regional authorities and the smaller and poorer towns and cities. One might therefore suggest that the reason why more large cities produces more IMO activity is that if more population centres across the region experience similar regulatory issues, their concerted and more coherent demands on the regional authorities are easier to meet than where there is strong imbalance between one or two large urban centres and the rest of the region. Furthermore, co-operation between the cities can effect solutions that merely need the blessing of the regional authorities, rather than the

regional authorities attempting through regulation to arbitrate between administrative areas that have fundamentally different circumstances – conflicts that they themselves may be financially involved.

Conclusion

In this chapter we have begun to develop a list of factors that influence the development of health insurance. With fairly small numbers (83 regions having introduced medical insurance in one form or another), it is difficult to establish statistical significance with regard to many relationships. Where possible this has been done, elsewhere support for some hypotheses must remain more contingent.

First and foremost, there is an over-riding and significant relationship between regional wealth and the functioning of insurance medical organisations. As indicated in the interview data, the under-funding of the health service, both through budget shortfalls and the low contribution rate, contributes to difficulties in maintaining a plural insurance system. Although it may not cost more to run (in spite of perceptions to the contrary), the pluralised model suffers from legitimacy in shortage conditions and for many post-Soviet administrators. Other elements, such as de-monetisation and absence of capital may also play a part.

Secondly, and contrary to assertions by many writers, there is very little connection between official party/bloc labels and resistance or support for pluralised health insurance. Indeed, rhetoric about "communists" and "Soviet mentality" from respondents in this light seem more invective than accurate. Indeed, to frame the implementation of health insurance as a matter of resisting or supporting the federal law (and thereby casting the argument in terms of the reformist-conservative debate) is somewhat misleading. Models I and II are both variants of accepted practice in the capitalist West. Although the topic of this thesis has been the attempts of two regions to enact the federal law as it was intended, with insurance companies rather than quangos funding hospitals (an aim which many other regions also undertook), it is clear from newspaper sources and also suggested by the analysis here that many regions saw the 1993 amendments allowing filials to insure as an opportunity to cut their own furrow using a single state-regulated insurance organisation.

Thirdly, although much attention has been paid to the problems of agricultural areas and IMO operation, the issue may have been incorrectly cast as a problem innate to agricultural areas, rather than a matter of poverty. However, it may be the case that where agricultural regions are more able to act, or where agricultural interests are more able to express their interests to regional government, they choose less marketised fund filial

insurance. Support for this proposition of "choice" comes from many regions with dominant industrial activity also choosing the filial model, despite the apparent compatibility of IMO insurance and industry.

Lastly and following from the previous two conclusions, there is a good deal of circumstantial evidence to support Stoner-Weiss' (ideologically neutral) theory of more and less effective regional regimes. Where regions successfully pursue a distinct economic policy, they also pursue a distinct health insurance policy. Where particular economic interests (agricultural or industrial) dominate regions, health insurance policy is also distinctive. It is worthwhile remembering that originally Volgograd Oblast' was an innovator in the introduction of medical insurance. However, this innovation could not be sustained because of institutional conflict, legislative inertia and under-regulation. In other words, what did for pluralised health insurance was not active opposition, but weak governance. Similarly, where population structures are less imbalanced between big cities and smaller settlements, there is more IMO development, suggesting that reduced potentialities for intra-governmental conflict permitted the development of the appropriate regulatory systems.

10. Conclusion

The conclusion consists of five parts. While attempting a broad summary, I also seek to establish five main findings of the research. These are focussed on the structure of the health insurance system and problems of its implementation. Other issues of social and political context are of course important; however they are not appropriate to be expressed as "recommendations".

In the first part I discuss the problems in health care reform related to wider social and economic changes – how they have impacted upon the models of insurance in Russia's regions. In the second part I discuss the advantages of the Petersburg model over that of Volgograd Oblast'. In the third part I assess the problems for governance created by the decentralisation of local government. In the fourth part I discuss the advantages held by St. Petersburg in being at the forefront of reform. Lastly I discuss the issue of reform initiative – and question the original premise upon which the insurance system was originally introduced.

The Soviet Legacy and processes of transition

I have sought to argue in this thesis that one of the key determinants of the development of the health system in the regions is the Soviet experience and the subsequent transition away from it. The removal of centralised hierarchical control clearly left many people within the health system bewildered. This is not a facile argument about the need for Russians to have a strong leader to prevent anarchy. It is clearly difficult to move from a situation where initiative and discretion were actively discouraged throughout the chain of command, (and in a society where behavioural norms were enforced often through implicit threats to livelihood and reputation) to a system of negotiation and agreement. Throughout the thesis this difficulty is alluded to. In chapter 6 I noted Ernst Neizvestnyi's comments on the confusion within Russian society between wilfulness and freedom. If initiative and independence was associated previously with opportunism and anti-social behaviour, the establishment of freedom delimited by good social norms is naturally going to be difficult, especially in the context of moral anomie created in the last years of Soviet rule. Two Petersburg municipal health care administrators broach the subject: one speculated that the ability to work within a more flexible system would take a generation to develop; the other bemoaned the continuing lack of division between the personal and professional in bureaucracies. The representatives of the medical workers have struggled, as have many unions, to separate themselves from the authorities; the ambiguity of tripartite relations has been too difficult to achieve in the context where unions have traditionally been a tool of control. The "telephone rule" of

awarding contracts to friends and the tendency of local leaders towards creating fiefdoms also reflects this problem. Whether or not it will change with the rise of a non-Soviet generation is not something upon which I will speculate – I simply do not have the evidence either way. However, the establishment of market and other negotiated relationships within health care has clearly proven difficult because of the legacy of Soviet governing practices.

The transition experience in this context has not helped. The introduction of market relationships within health can take on a variety of forms, and almost all "mature" health systems have experimented with them in one form or another. However, the dominant reform ideology of thorough-going market relationships throughout all social sectors is of a different order. As I have argued, this approach was produced by a coalescence of forces: the dominance of free-marketeers in the Russian government in key ministries (allied to the inertia and corruption in the health ministry), the sponsorship and occasional fiscal coercion of these figures by international agencies party to the Washington consensus, and the ideological context that made intermediate strategies unacceptable. In seeking to apply this to health, central policy makers at the beginning of the 1990s failed to appreciate the complexity of the system they were proposing, and had an unwarranted faith in the ability of markets to spring up in solution to social problems. In particular, the move towards health insurance as legislated for could solve only two aims: the ring-fencing of health finance and the establishment of quality control mechanisms. The Soviet legacy of measurement by intermediate targets – too many doctors, too many beds, run down capital stock – was not going to be solved by channelling funding according to set tariffs based upon current running costs. In part, the insurance scheme by itself has served to freeze these imbalances. The internal market reforms of the late 1980s on the other hand, helped to address exactly these issues, by strengthening primary care at the expense of the hospital sector. The decline in bed numbers was far swifter than anything achieved by insurance. It is ironic that reforms very similar to those introduced by Margaret Thatcher were abandoned by her Russian acolytes in favour of a system that actually enforces bureaucratic norms of care rather than ones determined by purchaser choice. Of course, their aim was probably ultimately to encourage greater private insurance, but this has happened only on the smallest of scales.

Wider transition processes also "made life difficult" for the health sector. Declining state fiscal authority, the collapse in public health measures, dramatically increased inequality and an ambiguous labour market (where the level of grey unemployment is high) have all sought to undermine the resource base for health just as the demand for health has increased, and its nature has been altered. Some hospitals and hospital wards are, in the words of one Petersburg administrator, becoming "hospices", while at the same time many

doctors are performing informal means tests on the patients coming in, in order to make up for their meagre (and often delayed) salaries. These processes naturally undermine morale.

Money

There are particular difficulties for the insurance system created by Russia's poor economic record in the 1990s, not least with the initial difficulties in setting up voluntary insurance. As we saw in Chapter 9, the economic well-being and economic profile of the region has a great impact on the kind of health insurance they develop. One of the debates at the centre of Russian health politics has been whether or not the variety of systems is a suitable reflection of different needs and possibilities, or whether for the sake of co-ordination and clarity there should be the same system across Russia. It is worthwhile reviewing what these issues are before we consider the ways in which St. Petersburg overcomes some of them in ways which are better than Volgograd.

Clearly one of the key problems in the Russian model of health insurance is the establishment of insurance medical organisations and their subsequent operation. The statistical analysis of the last chapter suggests that economic well-being is paramount. But what are the specific ways in which economic difficulty impacts upon the system?

The legitimacy of using IMOs to distribute funds becomes politically more vulnerable under greater conditions of economic hardship. The calls to remove one or other of the links in the chain become stronger, as evidence from around Russia demonstrates. Usually this means the IMOs rather than the funds, although in Volgograd Oblast' such suggestions were presented very much as an either/or choice. In the case of Volgograd this had resulted in the sidelining of the insurance companies – effectively undermining the whole process of medical and economic audit. Whether or not such calls are justified (some of the analysis in Chapter 9 questions this), it is clear that a system without popular support does not deserve to stay in place. There is little evidence of there being any further effort than the initial one to propagandise on behalf of insurance amongst the wider population, despite evidence of its general popularity amongst the upper echelons of regional government. The evidence from Chapters 7 and 9 suggest that a lack of preparation and state sponsorship of the IMO process has also undermined their position.

Poorer regions tend to indulge more in inter-accounting (*vzaimoraschet*) and the use of promissory notes (*vekselya*). This not only seems to offend the dignity of those within the system (being paid apples for operations), it increases the administrative burden and makes longer-term planning very difficult. Furthermore it also undermines the ability of the insurance companies to operate – they cannot economise and thus grow on the bartering

exchanges between the local power company and the local hospital. Conversely it strengthens the hand of the territorial funds, who have the scale and resources to cope with these systems. In such a context the insurance companies become ever more apparently superfluous.

Medical and financial audit is compromised in conditions of shortage. The insurance companies cannot enforce standards on the basis of withholding funds if there aren't those funds to withhold in the first place. Given the general hostility these innovations are bound to generate among the medical profession, it does not help matters to be subject to fines in a system already under-funded by half and more. Raising the quality of care and streamlining an inefficient system are two important priorities, and the main justification for the IMOs' existence. The relationship between the IMOs and the medical profession has been made tense by the apparent clumsiness of initial audit methods imposed upon a profession that previously was only basically assessed for its ability to follow dictated procedure. This relationship must be on better terms if the insurance system is going to work.

Poor financing of health encourages bribery and under-the table payments. This is creating an endemic problem. Attempts to legalise payments, apparently high on the agenda of many municipal health care chairs are dependent upon frontline staff being willing to expose payments to expropriation by the hospital or clinic – something they are understandably loath to do. If the relative level of bribery is related to the lack of funding, then the more one needs to introduce formal payments to stabilise funding, the more resistance *ceteris paribus* there will be on the part of the profession. There is a distinct possibility that under-the-counter payments may simply become endemic.

I think it would be unfair to suggest that the introduction of insurance was a mistake on the grounds of the poverty of the country. After all, it was not expected that the Russian economy would continue to recede for such a long period of time, nor by as much. However, to understand the problem of finance in the Russian health system it is important to understand the effect of this shortfall upon the complex of relationships within the system that determine possibilities and solutions. Significantly, **the first key finding of this thesis is this: that the introduction of insurance contributions has done much to combat many of these problems. Having been funded on a residual basis during the Soviet era, the health sector now has, in principle, a guaranteed source of income.** One of the main complaints regarding the introduction of insurance is that it has replaced rather than supplemented state funding. Considering the problems of payment for health by the municipalities, who rely on funding from the region and the centre whose taxation base is less effective than the territorial funds (social taxes are prioritised and have a far higher

collection rate than other taxes), it seems rather that the health sector has been part-protected from the collapse in state finance. When put to respondents the question "would the situation be better without insurance?" *every single one* of those asked (numbering 14) answered, albeit some of them reluctantly that it wouldn't. Financing simply would be less, and less stable. However, it is also important to remark that the level of contributions is not high enough. If insurance moves the system towards an expenditure principle (money is spent is determined by what services are rendered) it is clear that even under full collection and distribution of contributions, there would not be enough money to cover needs.

System Design

This research has sought to compare, within the context outlined above, two health care systems in Russia. It should be obvious to the reader that in all respects, the St. Petersburg system operates better than in Volgograd Oblast'. This is partly as predicted according to the simple notions that a more liberal city with experience of reform should operate better than a provincial region from the "red belt" of Russia. However, this thesis argues that what is also important is that the system design chosen by St. Petersburg is a key element in this achievement.

Insurance, the labour market and the inactive

That St. Petersburg is a wealthier region than Volgograd Oblast' and has a stronger fiscal base has obvious straightforward benefits, as the discussion of financial problems above shows. In addition people working within the budget sphere are naturally more content with the current system. Wages are paid on time, a larger proportion of taxes are collectable and are collected and so forth. This is especially true in relative perspective – how well their region is doing compared to the rest of Russia. However, in both sites there is still the need to square the welfare circle (after all, finance in St. Petersburg also falls short): where there is more social need there is usually less money to meet it. In St. Petersburg however, the distribution of difficulty is more even. There is no division of the population between the working and the non-working in terms of whom they are insured with and by. Money comes either from employers' contributions, (effectively a health tax, as there is no link between payment and receipt of policies) or from the city authorities. As a result there are no municipalities having to pay extra for a less active population (although unemployment and poverty still create problems for each area). There is also no threat, as there is in many Russian regions, of insuring only the working. The function of the division between working

and non-working then becomes a method of calculating the appropriate contribution from city coffers, and not a means of discrimination between patients.

The system depends on a stable and clearly monitored labour market. However, this did not obtain in Russia of the 1990s. The rapid rise and fall of new enterprises seeking to establish themselves (or take the money and run in some cases) means that many workers, although constantly in work, are moving from employer to employer with great frequency. As the experience of Moscow City has found, the insurance system has rapidly had to develop new technology to cope with the rapidity and frequency of this movement. There is also the issue of "dead souls" making the system more expensive to run. The level of grey employment and unemployment also complicates issues. People may be working in enterprises that do not have much contact with the tax authorities, or alternatively, they may officially be working, but attached to moribund or cash-poor organisations with a vested interest in expanding their employee numbers to lower the taxation on the wage fund. People may be reluctant to register as unemployed, or find it hard to get registered.

One might therefore argue that the introduction of insurance was premature insofar as the labour market was still very much in flux: there is instability of employer in new enterprises and ambiguity of employment in many of the old. The design of the Petersburg system avoids this problem simply by using the funds as an ear-marked tax for the health system. There is no need to know with whom someone is employed, nor are citizens at risk if their employer has not paid up. The one issue that may prejudice the welfare of potential patients is the *propiska* system. Although declared unconstitutional, Moscow and St. Petersburg continue to operate a system whereby living in the city requires permission on the part of the authorities, and is usually officially gained for those moving there through employment or marriage to someone employed there. As a result there are tens of thousands of people living in the two cities who are there illegally. (It is, incidentally, one of the laws used in the 1990s in the periodic roundings-up by the Moscow police of many residents from the Caucasus – *i.e.* Chechens and others.)

Institutional balance and openness

Chapter 8 considered the problems of the tensions between the insurance companies and the Territorial funds. It is one of the arguments of this thesis that the "mixed model" of health insurance – with both parastatal and independent insurers – is probably unsustainable, and proved to be so in Volgograd Oblast'. It has, as a number of respondents commented, more links in the chain than seems necessary. With the fund seeking to dominate, for the insurance companies to show their worth against the activities of the filials is simply not possible in

shortage conditions: audit is hard to enforce, and the accumulation of funds for investment in local initiatives nearly impossible. In any case, it is the fund that largely determines the rules of the game (He who pays the piper). It is naturally in the fund's interest to support its filials, and it is a means of exercising greater control over finances. St. Petersburg overcame this problem by instituting a municipal insurance company as insurer of last resort, rather than allowing the fund itself to operate in this area.

Secondly, the St. Petersburg territorial system, with only 26 insurants (the municipalities) rather than the estimated 100,000 employer-insurers that there would be in the territorial-productive system allows for greater stability and openness. There is less opportunity for the 'telephone rule' to apply: the municipal heads are not caught up in the management of enterprises seeking to siphon funds away, and their actions are to a degree more exposed to scrutiny. There is far less chance for the "threads to disappear" into a complex and over-populated insurance company market, as it was alleged was happening in Volgograd in the mid 1990s. There are only ten insurers involved in compulsory insurance in Petersburg (as opposed to the original 30-40 operating in Volgograd Oblast' with a population a third of the size), and all are dealing with large municipal contracts. Of course, insurance companies may go bust – but that is a risk of the system in general. What is removed in St. Petersburg is the possibility of the insurant going bust. This facilitates the development of the insurance market by removing the cost of that risk from the IMO.

The territorial fund in Petersburg has a vested interest in the stability and maintenance of the insurance market. It attempts to facilitate information flows - which are needed in a previously statistic-poor system. The problem of audit is not grounds for eliminating insurance companies, but rather a problem to be solved. Furthermore, the insurance companies themselves have a vested interest in improving a specific set of health care institutions. The introduction of general practice was fostered by insurance companies in St. Petersburg, as well as end-case payment in co-ordination with the municipalities. These were experiments possible in individual municipalities.

And significantly, the territorial system in conjunction with the use of municipal rather than filial insurance as the "safety net" allows for a clear line of authority. There is no ambiguity in the roles between the fund and the insurance companies. It is far clearer who is insured with which company. Relationships between health care units, municipal authorities and insurance companies are far clearer. In Volgograd this clear line of authority has been established only by the fund pushing out the insurance companies, but in a much less desirable manner. The municipalities have very little control over the fund, and there is no room to contest the relationship between insurant and insurer. There is also no dynamic of

improvement produced by implied competition for contracts, nor incentive to take part in or improve audit.

In short, **it is the second finding of this thesis that the territorial-productive insurance principle in Russia was probably a mistake.** Introduced partly as a means of generating interest on the part of the employer for the health of his/her workers, it has operated effectively as a hypothecated tax with no such incentives. It has introduced complexity into a system that is exacerbated by the fluctuating economic performance of hundreds of thousands of enterprises within a country undergoing traumatic and radical economic transition. The legacy of Soviet employment and taxation practice makes official statistics regarding the reserve labour force highly inaccurate. The principle does not avoid the problem of corrupt business and governing practices; indeed it seems as though it feeds them. It disrupts governance within the health system by fragmenting health care purchasers too much, preventing the development of longer-term relationships between purchasers and providers.

In addition to the rules of the game limiting competition in all systems (set tariffs, set contributions), because of the difficulty for institutions in developing relationships with insurance companies, auditing practices become standard. This threatens to reinforce inherited Soviet patterns of practice and resource distribution, especially during financial shortages. According to Twigg (1999) those who designed the system now recognise that the "system as implemented has not deterred many of the same perverse incentives which governed health providers' behaviour in the Soviet era" (1999:244).

By contrast the territorial principle allows for a stable insurance market within informed buyers (the municipalities), where health care purchasers can develop relationships with a geographically defined set of health care institutions. It is only indirectly dependent upon problems in the labour market, and allows both for competition amongst insurers and a certain degree of monopsony in purchasing.

Local Government and demography

A striking difference between St. Petersburg and Volgograd is the different institutional structures of governance and their impact on health care finance. Much of this difference is due to forces outside the control of these two federal subjects: the nature of local government as laid down by the central law on local self-government. The implications are threefold:

Firstly, the ability of the regional authorities to co-ordinate health care vastly differs. All municipalities in St. Petersburg are subordinate to the city. What the committee orders,

ceteris paribus, happens. In Volgograd Oblast' each city and town has control over the institutions designated its own municipal property. Thus while in Volgograd city there is a certain replication of the system of authority and co-ordination found in St. Petersburg, the Oblast' has a whole does not exercise authority over most of the institutions on its territory. The interconnection between funding and planning is broken. Thus Oblast'-level legislation regarding the territorial insurance programme bears little connection to the resources available to fulfil it in the municipalities, as the authorities there may have other budgetary plans or constraints. As a result the authority of the Oblast' within the health system is severely diminished. Health also becomes a less important matter at the Oblast' level as practical health issues press most urgently on units of government below it. This has obvious implications for any attempts to re-establish control over the system.

Secondly, the disparate and inherently conflictual political power structure within Volgograd Oblast' creates weak opposition to the unified territorial fund. The fund is able to take action, and to exercise authority over health care institutions through its role as majority financer in a manner that the budgetary institutions of government simply cannot. This has serious implications for democratic control over health and the possibilities of negotiating outcomes. The arms-length control over the fund by the Oblast' that its semi-autonomous status suggests means that intervening in the fund requires dramatic action which a weakened Oblast' authority with less of a concern for health is less likely to take. After all, it took three years for the Oblast' to re-establish control over the fund from the problems created by the proliferation of filials 1994-1997. Part of the institutional balance brought about by the territorial principle in St. Petersburg is reinforced by a unified administration far keener to act against the territorial fund.

Thirdly, the variable demographics of the Oblast' (with a strong industrial population centre and a large agricultural periphery) make for an uneven insurance field. Although the relationship between urbanisation and viable territory-wide insurance field appears more complex across the whole of Russia (dealing with the number of urban centres and so forth), it seems clear that in Volgograd Oblast' the fund has been willing to expand its influence through its role of insurer of last resort. There is an incentive to the fund, having already set up filials across the Oblast' to deal with dispersed populations and health care units, to edge out the insurance companies. This research has not considered in great detail the problems of health care in highly agricultural areas. I feel this is an appropriate area for future research.

These imbalances in power structures in Volgograd Oblast' imply a lack of internal and external democratic control over the organisation of health care. Health care

professionals and managers do not have access to the decision-making processes of the fund in the way that they do within health-care administrations and local government. Municipal authorities, deprived of funding, and unwilling or unable to get help from the Oblast' centre, are beholden to the territorial fund as the dominant coherent source of funds.

The third finding of this research is that too little attention was paid to the implications of local government reform for health care. The decentralisation of health care units to the lowest level is not only inappropriate for a social sector that needs to operate over a broader space. It also contradicts the funding mechanisms created by the insurance system. Those who legislate for, who control and who fund health care institutions do not – possibly *cannot* – co-ordinate their activities appropriately. It would seem appropriate therefore to establish control of the health system at the regional level – taking ultimate authority out of the hands of the cities and towns.

Previous experience of innovation

The vague notion regarding reform in former communist countries – that earlier experiences of reform help regions in adapting to new circumstances – appears to be thoroughly borne out by the research, with universal agreement that the Gorbachev-era new economic mechanism introduced into St. Petersburg, and Samara (then Kuibyshev) and Kemerovo oblasts helped them adapt to the new system of insurance. Firstly there is not simply the tradition of innovation, to which many in St. Petersburg alluded – the notion that there is pride in being in the frontline of experimentation. There are also recognised methods of innovation, and certain innovators. In St. Petersburg the use of various *raiony* to pilot certain reforms, in particular Kirov *raion*, certainly appears to have aided the development not simply of the New Economic Mechanism, but the development of more efficient payment systems within insurance.

Secondly, that the New Economic Mechanism had forced *khozraschet* conditions upon health care institutions five years before the introduction of insurance appears to have helped in terms of preparing those institutions for billing and internal accounting, and price-setting (although the post-Soviet liberalisation of prices made the actual prices previously set meaningless). By contrast, there appeared to be a "big bang" approach in Volgograd, with the whole Oblast' attempting to move to both insurance mechanisms of financing and a real (rather than formal) system of payments between institutions. This allowed for a wild proliferation of payment methods and large opportunities for corruption.

Whether or not it would have been wise for Volgograd and other regions to adopt more rigorously the New Economic Mechanism before moving to the full insurance is perhaps a futile debate. Not only would a mixture of systems across Russia have created accounting problems between territories, but the fiscal crisis may have encouraged swifter movements towards insurance anyway as a means of ring-fencing at least part of the health budget.

The fourth finding of this conclusion therefore is that experience of previous reform has patently been an advantage for St. Petersburg, and that this plainly mediated the shock of insurance. In particular, the city chose to build upon the internal market reforms and bend those reforms to suit their immediate situation. This suggests that big-bang approaches to health reform are unwise. The issue here is not simply *whether* insurance should have been introduced, but also *how*. There was very little phasing, with only minimal establishment of *khozraschet* in the regions before insurance was introduced. The rules of the game needed to be established with more guidance from the centre. It is worthwhile remembering that early on Volgograd was held up by the Federal Fund as an archetype for moving forward, before its own lack of institutional monitoring led to the effective collapse of the insurance market.

Politics, health care and societas economica

The research shows up one of the paradoxes of the reformist project in Russia. While there was great emphasis by Western governments and media and their friends in the Kremlin in getting the "right people" (and one may read a pun into that) elected and into positions of power, in the realm of health and welfare – one of great significance to the population – they seem to have very little relevance. What seems more important is the development of pluralist structures of power and influence – the meaningful inclusion of all relevant actors. The higher level of contentment expressed by St. Petersburg respondents seemed in no small measure related to the perceived openness of their system. Symbolic of this are two events – the removal at the behest of the union of Koryukin from the committee chair after he attempted to ban the trade union from organising in health care institutions, and the development of the medical association not simply as another top-heavy professional organisation but as a semi-formal talking shop to aid co-operation between the different subjects of the insurance system. In Volgograd Oblast' the relative weakness of the other actors in relation to the territorial fund (including the trade union and the insurance companies) came across in interviews as disturbing for the respondents; the lack of

openness, accountability and power on the part of the Oblast' cited as the source of most conflicts.

What is certainly true for both regions as key to the development of the systems is the presence of an initiator or an "initiative group" prepared to push through a particular system conception. In St. Petersburg, the innovator remained within the administration, whereas in Volgograd it was a group of individuals from various parts of the administration leaving to form insurance companies. It remains a subject for further research across the regions whether the focus of innovation has an impact on the ultimate development of the system. Certainly the chaotic explosion of insurance companies in Volgograd in the first four years of the system was identified as a reason for its necessary reform. It is also a moot point that the lack of such an explosion previously was the reason for the amendments made to the law on medical insurance in 1993.

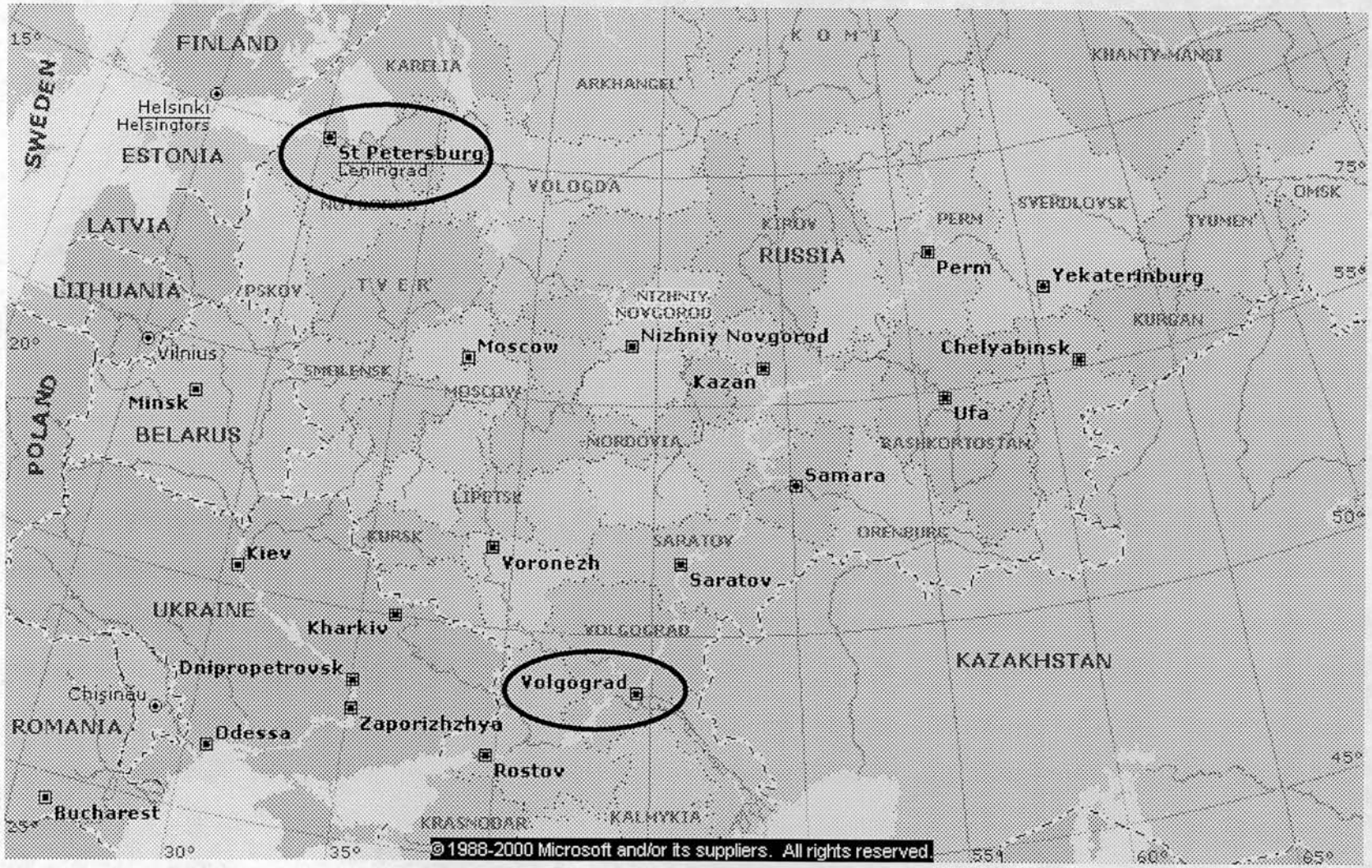
Furthermore, as Chapter 9 argues, there is some circumstantial evidence to suggest that success in implementing insurance depends upon a regional administration that can and will act to support it. While relative wealth is naturally an advantage, clear support, co-ordination and transparent regulation helps to sustain the new insurance system. Whether or not some regions are unable to achieve these because of governing structures and a fragmented economic profile is a moot point.

It is therefore the final finding of this thesis that the original idea of encouraging insurance companies to spring up organically was mistaken. The creation of an insurance market needs to be mediated and structured. The experience of MedEkspress in going to the Moscow-based Finance Ministry (Chapter 8) illustrates the extent to which this was not appreciated. The cause of these problems appears to have been excessive confidence in the ability of markets to arise naturally amongst individuals freed from state economic control – a belief not only in *homo economicus*, but *societas economica.*

The development of health insurance in Russia is a story of regions coping with a vague law handed down by a detached federal government. Questions of marketisation and liberalisation recede when one examines the key issues in health care – finance and governance. The health insurance law was supposed to cure the system of old Soviet habits – overstaffing, under-funding, a lack of clinical initiative and responsibility, and a passive population. There is little evidence it is achieving this. However, cannot be stressed too much that the law has been hampered by the poor economic situation in Russia, by the negative impact of the Law on Local Self-Government and by inertia from the authoritative bodies who could have provided a proper legislative infrastructure. It is clear that the

insurance system has stabilised health financing. St. Petersburg has shown how the Russian health insurance law might be made to work and can be used to encourage change and innovation.

Appendix I. A Map of Western Russia indicating the two sites



Appendix II List of respondents

(Where names have been used in the text they are indicated here)

St. Petersburg	*Volgograd Oblast'*
Administrators	
Kirov *raion*	Sovetskii *raion*
Nevskii *raion*	Tsentral'nyi *raion*
Admiralteiskii *raion*	Krasnooktyabrskii *raion*
Kolpino	Traktornyi *raion*
Petrodvorets	Dzerzhinskii *raion*
Vasiliostrovskii *raion*	Volzhskii
Petrogradskii *raion*	
Kalininskii *raion*	City Social Policy Committee representative
Primorskii *raion*	Oblast' Health Committee representative
City Health Care Committee representative	Deputy Mayor, Volgograd City (Anatolii Yegin)
Chair of Head Doctors' Association	
Professional Associations	
Chair, St. Petersburg and Leningrad Oblast' Union of Medical Workers (Vladimir Dmitriev)	Chair and Deputy, Volgograd Oblast' Union of Medical Workers
President, Medical Association	President, Volgograd department of Russian Association of Doctors, Rector Volgograd Medical Academy
Insurance Organisations	
Representative (responsible for strategic planning) Territorial Fund	Deputy Director, Territorial Fund
President, St. Petersburg Association of Insurance Medical Organisations	Vice President, Volgograd Association of Insurance Medical Organisations (Pavel Burkin)
President, MedEkspress insurance company	
Other key informants	
Editor, Meditsina Peterburga	Southern Russia regional correspondent, Meditsinskaya Gazeta
	Valerii Sabanov, Professor of healthcare organisation and insurance medicine

Appendix III. Interview Schedule

The interview guide was translated into Russian with the help of Ivan Boitsov, St. Petersburg State University, Special Philological Faculty

Interview guide.

Before we begin our conversation, I would like to outline the conditions of this interview

First of all I should like to explain the aim of this interview. The theme of my research is the introduction of compulsory medical insurance as part of the general transformation of the system of state welfare under conditions of the so-called "transition" to a market economy, or, if you will, a moving away from the general soviet system. I'm comparing the systems in St. Petersburg and the Volgograd region.

This interview will be used as part of the data for that research. As far as is possible, I will use this material under conditions of full anonymity on your part.

Unless you object, I would like to record this interview on a cassette recorder – not only because I am working in a foreign language, but most of all to preserve the authenticity of your remarks in the translation into English.

Before we begin, do you have any questions?

I would like to confirm that in this interview I am interested specifically in your experience, opinions and understanding, that which you as someone who works in the health system thinks about recent developments in health care – both in this city/region and in Russia as a whole.

Introduction

At the beginning of our conversation, could you tell me a little about yourself, that is:
How long have you occupied this position?
What were you doing before that?
Why did you come to work in this area?

What are the duties and responsibilities of your position?

What previous experience has helped you in your current work?

Do you feel you are typical of people in similar positions in other [health care, insurance *etc.*] organisations in St. Petersburg?

Devolution

I would now like to turn one of the questions that particularly interest me. Presently there is a particular distribution of duties and responsibilities between the federal, regional and local, that is, *raion* levels of power. As far as I understand, it's like this: the federal authority passes laws and gives out directives, the regions fulfil them, taking into account local specificities, and in [St. Petersburg/Volgograd] for example, the *raiony* have to organised actual medical assistance to the population.

How far you satisfied with the current distribution of responsibilities?

What advantages are there to it? What disadvantages?

What would you say were the greatest areas of conflict between these different levels of government?

- What would be the ideal solution to [a particular problem]?
- In your opinion, are there any particular barriers to this solution?

Some people have raised the issue of the integrity of the system. Do you feel devolution of responsibility for health care threatens the integrity of the system at the federal, regional or local level?

The influence of politics

In some western political circles, great store has been put by the importance of having reformists elected to government in Russia as opposed to conservatives and communists. This of course, has been in relation to the reform process as a whole.

Has there been any noticeable difference specifically in the nature of health policy and reform under [the regimes of Sobchak and Yakovlev/ Shabunin and Maksyuta?]

- Why do you think that there was [whatever change there was or wasn't]
- Would you say that was generally expected? What did you expect?

St. Petersburg only: Do you think St. Petersburg had an advantage in being a notably 'reformist' city? I've even heard it referred to in the past as the most 'apple-like' [*Yablochnii*][1] city in Russia.

Overall, how much influence do you think the directly elected politicians have over the development of health policy?

Other actors influencing health policy

Now I would like to turn to some questions related to the direction of health care policy.

How much influence would you say an organisation like yours has on the overall direction on health policy?

Do you think it would be right for you to have more influence?

- Why? (Why not?)
- What do you think is the chief obstacle to you having more influence?
- Do you think that is typical of many similar organisations in the political system as a whole?

Which other organisations and individuals exert the most influence over health policy?
[*Often prompts were used here to ask about trade unions, the territorial fund, IMOs etc. if they weren't mentioned*].

- What gives them that influence?
- Do you think there are other organisations whose contribution to the policy-making process would improve it?
    - What prevents them from being more influential?
- Are there organisations with too much influence?
    - Why do you say their influence is too great?
    - What gives them that extra influence?

Would you say that there is a difference between the formal structures of decision-making, and the real process?

- What is that difference?
- Are you happy with this situation?
    - (Why/ Why not?)

Markets and insurance in health care: access, efficiency, choice, quality of service

One concern raised in discussions of health care reform is 'access' [*dostupnost'* or *dostup*[2]] to health care services for patients.

What do you understand by 'access'?

- So if I understand properly, you would define access as "..."

Do you think that people are right to be concerned about problems of access? (Why?)

Do you think that the situation regarding access is improving or getting worse?

- What is behind that development?
- Do you see that development as an inevitable part of reform?

The insurance system, it is said, was introduced partly to "raise the 'efficiency' [*effektivnost'*] of the health care system"[3]. What does it mean to "raise the 'efficiency' of a health care system"?

So far in your opinion have there been improvements in the 'efficiency' of the system?

- Where there haven't been improvements, do you think it is because of the new reforms, or in spite of them?
- [Why?...]

Do you think that the insurance system is helping to improve the quality of services?

- How?/ Why not?

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[1] This is a pun on the name of the liberal party *Yabloko* ("apple"), whose name is derived from the initial syllables of its three founders.

[2] Respondents were invited to choose between the two; the former is grammatically speaking more abstract

[3] Here it sometimes helped to point out that the phrase existed in documents to which the respondent was a signatory.

The role of private medicine, voluntary insurance, and the status of medicine as an economic and a social good

The compulsory medical insurance system was designed to provide complete health care for all citizens. What I don't quite understand is this: Why do you think there was also provision made for 'additional, voluntary' insurance on top of this? What would it achieve 'additionally'?

- (What do you think the government was doing?)
- Do you think additional insurance is consistent with the universalism that the compulsory system is meant to contain?

Private medicine is becoming more significant, not only because there are more private practitioners, but also because the government and the regional authorities have made moves to make it easier to operate as a private doctor legally.

Do you welcome these developments?

- Why?

Is there anything that concerns you about these developments?

Do you think it is OK for those with more money to be able to have better health care?

- In [what/no] sense better? I'm thinking of speed of service, quality of service, quality of the food and surroundings and so on.

Consumer choice and rights; quality control

Another supposedly beneficial element of the introduction of insurance is the increase in the rights of the health care consumer - to choose the institution where he will be treated, and to have a greater say in the way he is treated.

To what extent have these rights been realised?

Has anything hindered the expression of these rights?

Do you think the strengthening of consumer rights is helping to improve the quality of the services provided?

Do you think that increasing consumer choice is a good way of improving the quality of medical services?

Why?

How else should or could quality control be realised?

Operational difficulties

We've talked about the various aspects of the reforms in terms of their outcomes so far – changes in quality, in efficiency, access and so on. I'd like to talk more about the institutional and operational problems that have been experienced in St. Petersburg in trying to put into place a system of compulsory medical insurance.

The 1991 law is, I think it's fair to say, a document that is rather short on detail. It leaves much of the detail to the regional authorities.

- What were the greatest difficulties in putting the 1991 law into operation?
- What were the most straightforward?
- Do you think that the previous reform of the system in St. Petersburg provided an advantage to the authorities? In what way?

Is there anything else you would like to say?

Appendix IV. Classification of Russian Regions

Kravchenko (1996; 1998) classified regions according to the extent to which insurance medical organisations were involved in the distribution of insurance money in compulsory health insurance:

Those above 90% funds distributed in this manner were classed model I (some funds will always be distributed by the territorial fund on strategic investment and insurance infrastructure)

Those with less than 10% distributed by IMOs are classified as model II

Those with between 90% and 10% of funds distributed by IMOs are classified as "mixed", model III.

Six regions do not operate the insurance model. They are model IV.

Model I (IMO model, plural model, legislative model)

Region	% Insurance money passing through insurance medical organisations
Kemerovo Oblast	99.8
Moscow City	99.7
Marii-El (Republic)	99.3
St. Petersburg City	**98.7**
Magadan Oblast	97.9
Kamchatka Oblast	97.1
Moscow Oblast	94.8
Novgorod Oblast	94.1
Khanty-Mansi Autonomous Okrug	92.9
Stavropol' Krai	91.6
Samara Oblast	91.4
Novosibirsk Oblast	91.3
Leningrad Oblast	90.9
Amur Oblast	90.0

Model II (Filial model, Fund model)

Region	% Insurance money passing through insurance medical organisations
Buryatia (Republic)	9.8
Altai Krai	8.8
Murmansk Oblast	3.9
Chelyabinsk Oblast	2.7
Chukhotka Autonomous Okrug	1.2
Khakassia (Republic)	.4

Sverdlovsk Oblast	.3
Adygea (Republic)	.0
Altai Republic	.0
Bashkortostan (Republic)	.0
Dagestan (Republic)	.0
Ingushettia (Republic)	.0
Kabardino-Balkar Republic	.0
Kalmykia (Republic)	.0
Karachai-Cherkessia (Republic)	.0
Komi (Republic)	.0
North Ossetia (Republic)	.0
Tatarstan (Republic)	.0
Tyva (Republic)	.0
Udmurtia (Republic)	.0
Khabarovsk Krai	.0
Primorskii Krai	.0
Bryansk Oblast	.0
Kursk Oblast	.0
Nizhniy Novogorod Oblast	.0
Orel Oblast	.0
Saratov Oblast	.0
Jewish Autonomous Oblast'	.0
Evenk Autonomous Okrug	.0
Koryak Autonomous Okrug	.0
Nenets Autonomous Okrug	.0
Taimyr (Dolgan-Nenets) Autonomous Okrug	.0

Model III (Mixed model)

Region	% Insurance money passing through insurance medical organisations
Vladimir Oblast	87.7
Yamal-Nenetsk Autonomous Okrug	85.9
Lipetsk Oblast	85.6
Irkutsk Oblast	85.2
Kaliningrad Oblast	84.4
Tomsk Oblast	83.8
Krasnoyarsk Krai	83.7
Ust-Orda Buryat Autonomous Okrug	83.5
Vologda Oblast	80.7
Perm Oblast	73.3
Voronezh Oblast	73.3
Orenburg Oblast	72.6
Chuvash Republic	71.1
Chita Oblast	64.7
Tambov Oblast	62.8
Sakha Republic (Yakutia)	62.4
Yaroslavl Oblast	61.7
Ryazan Oblast	58.0

Mordovia (Republic)	57.5
Tyumen Oblast	55.6
Volgograd Oblast	**52.6**
Astrakhan Oblast	52.3
Sakhalin Oblast	50.5
Tula Oblast	46.7
Arkhangelsk Oblast	32.9
Belgorod Oblast	31.6
Omsk Oblast	27.2
Kurgan Oblast	27.1
Ulyanovsk Oblast	23.9
Tver Oblast	23.2
Penza Oblast	22.7
Kostromo Oblast	21.8
Pskov Oblast	20.6
Kaluga Oblast	18.4
Krasnodar Krai	16.8
Rostov Oblast	15.8
Karelia (Republic)	12.2

Model IV (Administrative model)

Region	% Insurance money passing through insurance medical organisations
Chechnya (Republic)	N/A
Ivanovo Oblast	N/A
Kirov Oblast	N/A
Smolensk Oblast	N/A
Aga Buryat Autonomous Okrug	N/A
Komi-Permyak Autonomous Okrug	N/A

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